DOCUMENT RESUME

ED 239 086 CE 037 945

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|---|---|
| AUTHOR | Woods, Diane E., Ed.; And Others |
| TITLE | The Clinical Model in Rehabilitation and Alternatives. |
| INSTITUTION | National Rehabilitation Counseling Association, Alexandria, VA.; World Rehabilitation Fund, Inc., New York, NY. |
| REPORT NO | ISBN-939986-36-1 |
| PUB DATE | 83 |
| NOTE | 69p. |
| AVAILABLE FROM | National Rehabilitation Counseling Association, 633 S. Washington Street, Alexandria, VA 22314 ($5.00; 20 or more--$4.00). |
| PUB TYPE | Collected Works - General (020) -- Viewpoints (120) -- Information Analyses (070) |
| EDRS PRICE | MF01/PC03 Plus Postage. |
| DESCRIPTORS | *Educational Benefits; Educational Needs; Educational Objectives; Educational Policy; Educational Practices; *Educational Strategies; *Educational Therapy; Individualized Instruction; Intercultural Communication; *Models; Needs Assessment; Policy Formation; Position Papers; Program Design; Program Development; Program Implementation; Rehabilitation; *Rehabilitation Counseling; Rehabilitation Programs; Systems Approach; *Vocational Rehabilitation |

ABSTRACT

This book is a compilation of responses and reactions to a position paper by Dr. Joseph Stubbins entitled "The Clinical Model in Rehabilitation and Alternatives." The text of the position paper is presented along with a brief summary of the main points he made in it pertaining to the clinical model and the systems model. Also included in the volume are the following papers: "A Cross-Cultural Appreciation of 'The Clinical Attitude in Rehabilitation,'" by Paul Cornes; "Commentary on Joseph Stubbins' Paper and Monograph on the Clinical Model in Rehabilitation and Some Alternatives," by Patricia Livingston; "Comments on Joseph Stubbins' Material on the Clinical Model in Vocational Rehabilitation," by Monroe Berkowitz; "The Vocational Rehabilitation System," by David Vandergoot; "The Clinical Attitude in Rehabilitation Alternatives...A Reaction," by Donald Galvin; "Rehabilitation: An Historical Perspective," by Edward D. Berkowitz; "The Power in Positive Rehabilitation," by William Roth; "A Professional Colleague Responds," by Martha Walker; "Comments on the Clinical Attitude in Rehabilitation," by Harold Yuker; and "The Role of Academic and Scientific Communities," by Gerben DeJong. A summary by Joseph Stubbins of some conclusions reached at the meeting at Clark University and an assessment by Paul Cornes of the World Rehabilitation Fund Meetings on the Clinical Attitude in Rehabilitation and Alternatives conclude the volume. (MN)

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# THE CLINICAL MODEL IN REHABILITATION AND ALTERNATIVES

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# THE CLINICAL MODEL IN REHABILITATION AND ALTERNATIVES

**CO-EDITORS:**
Diane E. Woods *Project Director*
**International Exchange of Experts and Information in Rehabilitation**
Arnold Wolf, Ph.D., *Editor*
David Brubaker, Ph.D., *Editorial Consultant*
to: **Journal of Applied Rehabilitation Counseling**

International Exchange of Information in Rehabilitation
World Rehabilitation Fund, Inc.
400 East 34th Street
New York, New York 10016

ISBN #939986-36-1

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## FOREWORD

Dr. Joseph Stubbins, now Professor Emeritus of California State University, spent a sabbatical in England (1979-1980) partially supported by a World Rehabilitation Fund *International Exchange of Experts Fellowship*. During his time there, he studied the way vocational rehabilitation services are delivered, including how the disablement resettlement officer (DRO) functions, how DROs are trained, how the employment quota system works in the United Kingdom, what policy questions are dealt with or not dealt with and how the "clinical attitude" or lack of it affects the delivery of rehabilitation services and ultimately the successful employment of people with disabilities.

Dr. Stubbins then prepared a monograph for publication by WRF in 1982. In the monograph version of a much longer manuscript, in addition to discussing the British system and comparing it to the U.S. system, he raises some provocative considerations with regard to the limits of clinical methods and offers some alternatives. He pleads for rehabilitation experts to get involved in the forums where policies are really decided, and outlines some policy issues that might engage the combined attention of disabled persons, the rehabilitation community and the community at large, viz: the organization of rehabilitation services, income maintenance, program evaluation and delivery of services.

Dr. Stubbins' monograph emphasizes the importance of cross-cultural exchange of ideas in rehabilitation in order to improve on existing attitudes, practices and policies. It became the 16th entry in the International Exchange of Experts and Information in Rehabilitation monograph series sponsored by the World Rehabilitation Fund under a grant from the National Institute of Handicapped Research and was distributed in 1982.

The monograph enjoyed both popularity and controversy, and it was decided that WRF would arrange for "utilization efforts" around the monograph. Plans were made for several seminars to be held in March 1983 with Joseph Stubbins as the key speaker and Paul Cornes, Senior Research Fellow with the University of Edinburgh and an expert on rehabilitation policy in the U.K., as chief reactor, providing an international view. WRF sponsored Cornes' visit to the U.S. and Stubbins' visit to the East Coast, and arranged for meetings and participation at several sites, including:

- Michigan State University
- New York University
- Hofstra University
- Washington, DC (co-sponsored with the **National Council on Rehabilitation Education**, prior to APGA conference)
- Clark University
- City University of New York-Graduate Center

In addition to Paul Cornes, other individuals representing several disciplines in the U.S. (public and social policy, economics, history, rehabilitation,

administration, rehabilitation research) were asked to respond and react to Stubbins' position paper, The Clinical Model in Rehabilitation and Alternatives, at several meetings.

This book is a compilation of Stubbins', Cornes' and *some* of the other reactors' presentations. The reader should be advised that the papers were written for *oral* presentation (except for Martha Walker's) and it was decided not to rewrite or significantly edit any of them. The editors feel and hope that the content of the papers will provide a wide-ranging audience of rehabilitation personnel with a broad spectrum of offerings of opinions for their consideration, review, further discussion and possible action. We hope that the inclusion of reactions from outside the rehabilitation field per se will continue a dialogue which is important in considering issues which relate to the enhancement and enrichment of the lives of people with disabilities. Although the meetings held in March '83 reached audiences of about 350, it is hoped that this monograph through universities and agencies will reach thousands of concerned professionals and consumers.

That the *Journal of Applied Rehabilitation Counseling* and the National Rehabilitation Counseling Association, a division of the National Rehabilitation Association, agreed to co-publish this monograph with the World Rehabilitation Fund (International Exchange of Experts and Information in Rehabilitation) in order to make the material available to its readership is an encouraging step forward in collaboration in rehabilitation.

**Diane E. Woods**
**Project Director**
*International Exchange of Experts and Information in Rehabilitation*
*World Rehabilitation Fund, Inc.*

The main points which Stubbins made to which the reactors responded are summarized with ten points listed under the clinical model and ten points under the systems model:

### Examples of The Clinical Model

(1) Clinical methods are grounded on an encapsulated view of human personality and accord too little attention to the permeable nature and problematic character of that which separates *within* from *without* the individual.

(2) Individual diagnosis and treatment are most beneficial to those persons who already possess resources for adapting to disability and leads to those with least resources.

(3) Pragmatic and research attention to individual psychological and vocational aspects have been well funded while ecological approaches have been neglected.

(4) Emphasis on clinical methods and individual treatment have tended to obscure the common denominators in the lives of disabled citizens which are amenable to redress at the social level.

(5) Techniques of clinical methods should be supplemented by analyses afforded by sociological, economic, political and anthropological insights into how clinical appraisal and treatment are influenced by professional-guild interests of rehabilitation practitioners.

(6) Clinicians have ignored the contradiction inherent in: (a) rehabilitation counseling can return almost all disabled persons including the severely impaired to employment provided sufficient resources are committed; (b) some clients are untreatable because of circumstances beyond the clinician's control, e.g., disincentives of entitlement programs.

(7) Clinicians tend to gravitate toward those with the best prognosis—which is built into the accountability system of the state-federal programs. For the same reason, they have least interest in the congenitally disabled, older and long-term unemployed and those with behavioral problems.

(8) The mainstream of vocational rehabilitation has not challenged the rationale that services are justified by the number of clients transformed from unemployed status to gainfully employed. This rationale has nurtured abuses and is particularly untenable in periods of high unemployment.

(9) The trend toward specialization of those professionally closest to the disabled has left policy issues in limbo or to the vagaries of political scrambling.

(10) The professional roles of senior rehabilitation personnel (administrative and academic) should be enlarged to include policy studies.

### Examples of A Systems Model

(11) Rehabilitation literature lacks an integrated view of disability problems since each of the social science disciplines tends to disregard the per-

spectives of the others.

(12) A system is a cluster of variables assumed to be related to disability and rehabilitation.

(13) The success of mental retardation programs is an example of systems-methods-in-practice. Psychological approaches have played a minor part in this success compared to state and federal legislation, use of the public media, community education, advocacy with employers and strategic use of political influence.

(14) The identification of systems' factors that affect the careers of disabled persons would enhance the efficacy of clinical methods.

(15) Systems approaches would juxtapose individual methods of vocational rehabilitation with group and social ones (quota system, tax incentives to employers), compare their cost effectiveness and lead to more rational rehabilitation policies.

(16) A social systems approach would attempt to explore successful interdependence between disabled and non-disabled persons and the factors that tend to create social distance between them.

(17) A system of disability-variables would assume interacting effects among societal forces that condition the exchange of goods and services, how these are allocated by authoritative figures and laws—or, more broadly, how cultural factors interact to produce the social and economic disadvantages under which most disabled persons live.

(18) Rehabilitation practices are a conflation of science (measurement of individual differences, behaviorism) and ideology (romantic individualism). Since systems approaches can be interrdisciplinary and cross-national, they may help to separate ideological components from scientific ones.

(19) The natural world does not readily give up its secrets but it usually does not mislead. The social world or social system, however, is guarded by an elite and their allies (e.g. the professions) who ensure that it is perceived and understood in particular ways. Tax supported rehabilitation institutions are the culture-carriers of the prevailing definition of disability (personal deficits) and remediations (counseling).

(20) Public acceptance of systems approaches can be advanced by analogies to business systems, emphasizing their traditional character and the choice of language free of political extremism.

## THE CLINICAL MODEL IN VOCATIONAL REHABILITATION,
## By Joseph Stubbins

Vocational rehabilitation is now in a crisis because it cannot make good on its promises. After decades of generous funding for professional training, research and development and the state-federal programs, the level of unemployment among the disabled remains at an unacceptably high level—about five times that of the general population. The crisis is not primarily due to supply-side economics and the Reagan Administration's efforts to contain inflation. The fault lies essentially with the clinical model as *the* means of assisting impaired persons to gain access to the economy. *The clinical model has been a decoy that prevented both professionals and disabled persons from understanding the ecological aspects of disability* (Stubbins, 1982 a). This paper will develop how the clinical model evolved in this direction and the need to return to the drawing board for more effective ways of understanding the problems of disability.

### The Batting Average of Vocational Rehabilitation

From 1920 to the present, the rationale for vocational rehabilitation was that it was an investment that returned disabled persons to the labor market and resulted in savings to taxpayers. No doubt, most professionals in our field recognized this rationale was a strategy to separate vocational rehabilitation from other welfare programs opposed by conservative elements in the

Congress (Berkowitz). If vocational rehabilitation remained a sacred cow until recent years, it was due primarily to the general consensus that this was not a give-away program but an investment in making disabled programs self-supporting. However, practitioners could not make good on this claim except, so to speak, by rigging the game; it was a matter of political realities.

To make good on the claim that vocational rehabilitation was cheap, "creaming" became inevitable. Washington wanted statistics to support the efficacy of vocational rehabilitation and triggered a message down the hierarchy. The line counselor could not pass the buck and some how they managed to come up with the data that was expected of them. It may be inexpensive to train a person needing a set of dentures and put him in the job, but the kinds of persons who were increasingly presenting themselves had much more severe problems. Continued advances in medicine increased the backlog of persons surviving illness and injury. Raising the level of financial support hardly made a dint in this group. The sheer number of severely disabled ultimately led to the question of who was entitled to priority in service. It was easy to exclude any severely disabled person on feasibility grounds, that is, that the provision of services would not likely result in his or her employment. The feasibility criterion, however, did not exclude the politically sophisticated who know how to bring pressure to bear to obtain what they wanted from the program. But these were a minority among the disabled. The 1973 Amendments to the Vocational Rehabilitation Act opened up vocational rehabilitation services to the severely disabled as a matter of right. This mandate turned out to be a severe test of the clinical model since these were people who would otherwise not succeed in getting jobs. Each of you can decide whether vocational rehabilitation passed that test. I do believe, however, that increasing political clout of those formerly excluded from services in combination with other events, has dealt a stunning blow to the public's image of rehabilitation.

Even when significantly handicapped clients were given a wide range of services during periods of high employment, only about 1/3 of them were placed in jobs. The batting average with clients referred by SSDI and SSI was much worse and hardly worth the money spent on these programs—this despite the fact that those referred were presumably among the top three percent with regard to rehabilitation promise.

## Changes Affecting Vocational Rehabilitation

The rise of consumerism and activism among disabled citizens generated distrust of vocational rehabilitation (DeJong, 1979). Disabled persons had priorities different from those of professionals and more counseling services were low on their list. They were concerned about gaps in existing services such as transportation, architectural barriers, and housing. They began to resent the assumption that the disabled had deficits that needed to be treated by professionals. To them, vocational rehabilitation services were distrac-

tions from the basic problems faced by disabled persons.

The simplicity of the original idea that the disabled person would be quickly trained for a blue-collar vocation applied to a declining percentage of the existing pool of potential clients. The mix of this pool had changed greatly over the past 40 years. Most of the present clients were earlier thought to be non-feasible, viz., persons with severe physical disabilities, recovered psychiatric patients, mentally retarded, hard-core unemployed youth who qualified on some technicality, young adults without any work experience and so on. In relation to their overarching problems, the usual processes of vocational assessment tended to be irrelevant. They required some developmental experiences in pre-vocational programs, workshops and in special projects with industry before they could be considered for the open labor market. Rehabilitation counselors tended to show little interest in this group and facilities for them were poorly staffed.

The traditional rationales for vocational rehabilitation were collapsing because of technical successes that enabled the physically handicapped to move freely in the community as well as advances in vocational rehabilitation itself. As to the latter, we have the dramatic example of hospitalized retarded persons being trained to live in the community about half of whom actually earned their own living. Behavioral counseling greatly expanded the scope of those who could be trained for vocationally useful work. Many of you will think of other developments that eroded the logic by which Mary Switzer sold vocational rehabilitation to the Congress (Berkowitz,). Ironically, vocational rehabilitation was undermined by its success. By that, I mean that the capacity of the economy to absorb workers could not keep up with the additional ones seeking to enter the labor force. What was most detrimental to the idea of vocational rehabilitation as an investment in producing qualified workers was the emergence of chronically high levels of unemployment and a growing consensus that technological change and free trade would keep unemployment at a high level indefinitely. From a purely economic viewpoint, it made no sense to invest in vocational rehabilitation.

Rehabilitation specialists ought to confront the fact that individual vocational services can no longer be rationalized by the needs of the labor market. Can we find other compelling reasons to justify the fullest vocational development of those who are kept out of remunerative employment? I think we can.

## The Future of Clinical Services

With an increasingly aging population, it is safe to assume that at least 50 percent of the disabled will remain outside the economy for the indefinite future. This suggests that vocational rehabilitation should no longer hitch its fate to how well it does in job placement and gamble on other justifications. I'm suggesting that we go back to the drawing board to redesign what we can do to improve the lives of disabled persons in our roles as social scientists and

psychologists. The alternative is to face a gradual obsolescence of vocational rehabilitation.

Mary Croxen (1982) in her report concerning the social integration of disabled people to the Commission of the European Communities suggested that the word "employment" be extended to include any socially useful work even when not remunerated. Her suggestion is quite attractive. It would in time do away with the invidious distinction between paid and unpaid work and reduce the guilt associated with leisure activities, lessen the stigma of unemployment, and provide a foundation for publicly supported services aimed at teaching disadvantaged persons how to be "employed" when there is no need for them in the economy. There is no need to stress the physical and psychological impact of long-term unemployment even when there are alternative sources of income.

If all persons in the welfare occupations consistently used the word "employment" in the manner suggested, it would force others to adopt terms such as paid employment when they wish to make the distinction. One can overemphasize the importance of this semantic device; on the other hand, the strategic uses of language are important aids to social objectives. Thus, advocates have insisted on speaking of retarded citizens, persons, people, or youth rather than "the retarded." Negroes and colored are now blacks. Most professional journals have policies against sexist language.

At any rate, I visualize programs aimed at full "employment" for handicapped persons as giving clinical approaches a new lease on life.

## Social Psychology and Social Darwinism

It might be useful to ask: How did vocational rehabilitation get into its present dilemma? One approach to exploring rehabilitation's loss of support is to examine the basic influences to which rehabilitation counselors are subjected in the course of their training. Counselors are trained by clinical and counseling psychologists, and the evolution of these branches of psychology has had a great influence on our field.

The founders of the National Council on Psychological Aspects of Disability (which later became the Division of Rehabilitation Psychology of the American Psychological Association) were social psychologists. Many of them were influenced by Kurt Lewin and were politicized by the trauma of the Great Depression of the 1930s. They viewed disabled persons as victims of social injustice and were interested in uncovering the social processes by which a person may be sought after and respected at one time and after acquiring a disability loses friends and his means of earning a livelihood.

That early commitment to exploring the social dynamics of disability (which today we might call a systems approach) was lost as more and more counselor educators became primarily clinicians. To the extent that this happened, there is little that is distinctive in rehabilitation psychology. One indi-

cation of this is that clinical and counseling psychologists move into rehabilitation settings without difficulty and work alongside rehabilitation counselors and frequently supervise them. Essentially we who train rehabilitation counselors do so by virtue of experience rather than as functions of distinctive training and orientation. Certainly, our approach is not primarily social psychological or sociological. Rehabilitation psychologists are occupied with narrow gauge pragmatic issues usually relative to a single disability. Very few are committed to exploring the problematics of why and how disability devalues the person and the possible connections between status loss and features of the socioeconomic system.

Rehabilitation psychologists are among the severest critics of the medical model. Yet in following the clinical model, we are closer to that paradigm than we realize.

Our concentration on individual differences gets its inspiration from the popular credo of romantic individualism (Wyllie, 1954). The zenith of the vocationally successful handicapped person is perhaps a lawyer in private practice who charges his clients $125.00 per hour! Though this lawyer may not enjoy the same social status as others of his income, he is tolerably happy with friends of somewhat lower status. He is an example of how being visibly impaired is not necessarily an obstacle to vocational success and happiness. As to others with similar impairments, they simply differ from him in their individual traits—possibly less intelligent, less determined and less socially skillful. Such thinking can serve the function of protecting the practicing counselor from believing he has failed his clients. On the other hand, this same counselor looking in the mirror is reminded of how close he is to the precipice that leads to the untouchables. How often does he re-assure his clients that if he has not been helpful, it is because counseling is not the answer to their problems?

Psychological components in vocational rehabilitation such as humanism, empathy and similar influences of psychotherapy obfuscate our kinship to social Darwinism (Hofstadter, 1955). We believe that disabled people are arranged pretty closely to where they deserve to be, especially after receiving the benefits of rehabilitation counseling. Our benign intentions for our clients tend to remain insulated from what actually happens to them.

## The Sociology of Rehabilitation Practice

A profession should constantly monitor how its economic and guild interests (Larson, 1977) subtly influence the consciousness of clients and practitioners (Sampson, 1977). How well have we met this responsibility? This question is particularly addressed to those in the universities who enjoy the semi-protection of the academic tradition of freedom from political pressures. Have those of us in the universities used this freedom to point out the limitations of clinical methods to colleagues in rehabilitation institutions?

Individual treatment has pretty well absorbed our resources for understanding disability problems and there was little left for explaining why a majority remained unemployed. We and the counselors we train have dangled before prospective clients the lure that vocational diagnosis might uncover some hidden talents and have been less than forthcoming about the administrative pressures to distribute clients among the currently available job openings, many of which go begging even in good times. Counselor educators have invested trait psychology and vocational counseling with great power to transform the lives of disabled persons. Perhaps, it is time to take a fresh look at how the strain toward professionalism has affected our ways of analyzing disability problems.

Thirty years ago, psychologists were more apt to be broadly educated in several of the social sciences and in the philosophy of science. The knowledge explosion in psychology has tended to restrict this breadth in favor of technical expertise applicable to a narrow range of practice. Rehabilitation psychologists are more concerned with being in touch with the latest developments relevant to limited technical issues than with the broader issues which is the subject of this paper. Not many of us stop to wonder how a sociologist, political scientist, economist or anthropologist might view the problems with which we are daily engaged.

This trend toward reducing disability problems to technical issues has resulted in freezing rehabilitation psychology into a narrow positivist groove. For example, rehabilitation journals have a marked preference for data-based papers even when they deal with insignificant matters. Such papers often suffer from the triviality resulting from accessible data seeking a respectable methodology. Issues such as the very high level of unemployment among the disabled presumably do not excite many rehabilitation psychologists. Nor are many psychologists interested in the numerous disincentives to regular employment built into the means tests for medical care and money transfers for the severely disabled.

In adapting to the economic benefits of professional psychology, we have moved further and further away from the origins of rehabilitation psychology as a broad based effort to understand disability regardless of where the issues led. Simultaneously, the basic interests of disabled persons and our own have diverged.

Rehabilitation psychologists are well within the mainstream of professional clinical psychology in viewing the disabled person as an object for clinical practice and research. In this perspective there is little room for considering the lived life of the disabled as a form of social pathology and for coping with the moral issues posed by the disadvantages which they suffer. A younger generation of rehabilitation psychologists have tended to detach themselves from such considerations with the purpose of becoming purer scientists. This development has widened the existential gap between practitioner and patient. Many handicapped persons view professionals in reha-

bilitation as feeding off public funds which could be better used to support the independent living movement, advocacy for educational and employment opportunities, self-help ventures and needed legislative measures.

Counselor educators have ignored the fact that wherever the disabled have succeeded in organizing themselves independently of professionals, they have placed clinical services at a low priority. This suggests a meagre overlap between their interests and those of rehabilitation personnel. The differing perspectives of client and practitioner might be posed as an anthropological problem. There can be no clinical attitude without persons who treat disabled people. The clinician is not only a man or woman with knowledge and skill. He or she does this work to earn a living and to achieve status, experiences variable needs for security, autonomy, appreciation for competence and involvement, etc. In the life-world (as contrasted with learned monographs), clinical methods are enmeshed with the pursuit of personal needs and organizational pressures.

Professionals engage in certain activities that bear no relation to the problems their clients share. A major interest of professionals is to create and maintain a monopoly of expertise to which there would be limited access. For example, rehabilitation counselors are striving for licensing. But I am not aware that disabled persons consider this necessary.

The foregoing is another way of stating that individual services is a small segment of the totality of disability—and currently not the most pressing one.

## A Systems Approach

Social criticism is sometimes brushed aside when not accompanied by alternatives. However, if it can be demonstrated that clinical methods are less cost effective than claimed, that they place handicapped persons in a dependency relationship with experts and that they consume resources that could be more profitably used in other solutions, then the criticism should not be dismissed. Most of you have ongoing responsibilities for the training of psycho-social professionals and would need to effect a transition to other models of rehabilitation. You might, therefore, expect me to suggest alternatives. But I have no agenda for such a transition. We can struggle to adapt the philosophy and methods of systems which have evolved elsewhere. It is well to recall that rehabilitation counseling itself developed out of the amalgam of applied psychology, social work and medicine.

Clinicians in vocational rehabilitation were able to exploit developments in applied psychology which have emerged over the past 60 years. In spite of substantial funding for research and development in vocational rehabilitation since 1955, most of what we do as rehabilitation clinicians are adaptations from the fields of developmental, clinical and counseling psychology. Fresh new ideas do not appear very often as those of you who have been in the field for 20 or 30 years realize.

In systems approaches, we will have to exploit the social sciences of eco-

nomics, sociology, anthropology, political science and psychology for the broader understanding of disability. A productive model of vocational rehabilitation must recognize that remedial measures would take into account the insights concerning the distribution of valued goods and services, the structure and dynamics of society, how other societies deal with disability problems, issues of social and political power and, of course, individual differences among disabled people. What is common to most of these disciplines and largely absent from American psychology is that the problems of disability are generated by societal structures and therefore solutions are to be sought at the social level. By contrast, the hegemony of trait psychology has supported the prevailing ideology that almost everyone is where he or she deserves to be in the socio-economic hierarchy.

In a systems paradigm, we would have to abandom the notion of linear relations that presumably explain successful vocational rehabilitation. In its stead would be the concept of a system. A system is any set of "interesting" variables that are presumed to influence each other and to be relevant to certain concerns (Easton, 1979). This definition differs from mechanical and organismic systems with boundaries that distinguish them from the environment. The boundaries of our notion of system are set by what is likely to influence our practical interest in getting clients back into the economy, obviously a more flexible construct than those systems with physical boundaries. By contrast, counselors' exclusive attention to individual clients and treatment designed to shape them into being more employable gives us a blinkered view of the reality of disability.

In the short run, clinical methods are more attractive than systems methods. Rehabilitation counselors are already trained clinicians. They have a recognized repertoire of techniques and more or less of a professional identity that is valued among welfare agencies. Organizations expect their psychosocial workers to work with clients individually in certain prescribed ways. On the other hand, systems approaches to rehabilitation are at an early phase of development. For the present, they are largely a point of view and a philosophy of social science that point in certain directions and have yet to develop an agenda for research and practical applications (Sutherland, 1973). But it has already had some successes. The phenomenal improvements in the social and employment status of mentally retarded citizens resulted from systems changes. The retarded still have profound intellectual limitations. However, through the removal of irrelevant literacy tests, influencing hiring practices and substantial changes in how the public views retarded persons, their social and economic climate has greatly improved.

### Rehabilitation Programs Abroad

Another vantage point from which to view systems approaches is to examine rehabilitation programs in other Western industrialized countries. In

the United Kingdom and most West European countries, proportionately far less is spent on individual approaches in facilitating entry or re-entry of disabled persons into the labor market. Other countries have largely relied on quotas for the employment of the disabled, levies against non-complying employers, financial incentives to cover the greater cost of inducting handicapped workers, and government sponsored sheltered workshops where workers are paid the prevailing minimum wages (Stubbins, 1982 b). Presumably national and ethnic frontiers should not interfere with the flow of scientific information. Unfortunately, the systems methods employed by the West European countries when broached here are usually cavalierly dismissed with, "It wouldn't work in the United States."

The difference between American and European approaches is a matter of emphasis and the allocation of resources. Because programs abroad lack certain positive features found in the United States need not rule out adapting the best of their devices. In the United Kingdom, West Germany and Japan various functionaries do individual counseling (Manpower Services Commission, c.1979) (though it does not carry this label) just as in the USA we have *Targeted Jobs Tax Credits*, affirmative action provisions of the 1973 Amendments to the Vocational Rehabilitation Act and some other schemes based on the assumption that, at least in part the problem of work for the disabled lies with employers.

American technological superiority in certain areas perhaps obscures the fact that most of our social welfare programs—e.g. workers' compensation, Social Security programs and prepaid medical care—arrived rather late in the USA and were often modelled after European programs. Even when certain foreign rehabilitation programs are quite unacceptable here, the exploration of this rejection and the attempt to view it in an anthropological context (Adler, 1982) could have practical implications for the research and development of rehabilitation policies. The study of programs of vocational rehabilitation abroad should not be regarded as a hobby for retired professors and those on sabbatical alone! The effort to make sense of foreign rehabilitation policies is a good introduction to a systems perspective.

## Some Issues for Systems Study

Once committed to a systems perspective, typical clinical issues are seen in a different light. The clinical model is fundamentally a closed system bounded by the intrapsychic tendencies of the client on the one hand and by the repertoire of diagnostic and intervention techniques of the counselor on the other. We know, for instance, that low risk clients for rehabilitation services tend to be younger, less severely disabled, have more formal education, are married and have a continuous work history as compared to high risk clients. One implication of such findings is to give the low risk clients priority in order to show results for the money being spent. However, in a systems perspective, this kind of information is only the first step of an inquiry. Since the

low and high risk clients seem to differ with respect to access to the opportunity structure and to psychological and social support, the next problem might be how to transform the high risk clients into better prospects for employment. The vocational rehabilitation clinician usually views his chances of achieving closures (status 28) in terms of the psychological quanta *inside* the client. For example, is the client motivated or not?

The client may not be motivated for any number of reasons. One reason might be that he or she is already receiving entitlement benefits at or above the level of his customary wage. Another reason might be his belief that any kind of work would aggravate his disability. In both instances, we need not assume that the possibility of understanding and motivating the client is exhausted by the vocational and psychological diagnosis. Other possibilities outside the purview of the clinical model exist. I am juxtaposing the clinical and systems approaches to illustrate this.

(1) *Clinical paradigm:* Most disabled persons can be counseled to improve their competitive prospects for finding a job. The others are less motivated or less able.

*Systems paradigm:* Most persons respond to rewards and punishments currently in effect in the socioeconomic system. Motivation is largely a function of the individual's perception of the system and how it objectively affects that person.

(2) *Clinical research:* Identifying and measuring the personal skills which are currently in demand in the labor market and counseling people to be realistic.

*Systems research:* Identifying the situational factors of those who remain cut off from social and economic rewards and devising programs for their induction into the work force.

(3) *Clinical policy:* How to gain the support of national and state governments to support the delivery of vocational rehabilitation services by professionally trained and licensed personnel.

*Systems policy:* How to develop a coterie of vocational rehabilitation personnel responsive to the changing economic, social and political trends that influence the welfare of disabled citizens.

(4) *Clinical self-image:* Vocational rehabilitation involves a complex set of skills possessed only by experts explicitly trained for these services. Progress in vocational rehabilitation depends largely on defining the scope of this expertise and restricting its practice.

*Systems self image:* Solutions to disability problems require the co-operation of a wide range of experts and scientific disciplines. The co-operation of lay leaders should be sought in convincing governments to support reputable scholars from various disciplines in developing programs of various policies, practices and research.

No matter what we conclude the vast majority of counselors, counselor

educators and administrators will continue to adjure disabled persons to learn more about themselves, to become more saleable in the current labor market, to be more assertive, and to gain the jobs which somehow have escaped some ten million Americans. All this is stubbornly ideological, built into our institutions and so illusory. One of our major responsibilities as advocates is to help handicapped people explore how closely their own experience in education and work matches that conveyed by professional helpers. This might open the road to a more authentic identity for disabled persons. Perhaps this is already happening as more and more of them have decided that disability is not simply impairment, loss of function and failure to exploit one's personal resources. Their physical, social and economic environment disables them (Bowe, 1978; 1980). Disability is the loss of erstwhile friends in pursuit of upward mobility, the places that cannot be entered, the jobs for which disabled applicants are not even considered, employers' attitudes and economic interests, a patchwork quilt of legislation, and the double indignity of being victimized and patronized. In relation to this domain of variables, a disabled person's competencies, traits, and liabilities may very well add up to little in the search for work.

Let us try to unravel the processes by which most of the physically different and psychologically deviant are transformed into second-class citizens. Let us work on the assumption that the illusive answer to the status loss suffered by our clients lies deep within the structure of society and that their current behavior and consciousness are clues to the nature of their social reality.

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## SOME ISSUES/QUESTIONS FOR DISCUSSION RAISED BY COLLOQUIUM REGISTRANTS

1) To what extent would the elimination or serious curtailment of those services subsumed under the "clinical attitude" lead to less effective rehabilitation for either vocational or independent living goals?
2) To what extent is the masters degree standard for rehabilitation counselors, a realistic response to the performance requirements of RCs as opposed to self interest on the part of counselors, educators, and the serving agencies?
3) Is there really any reason why the social, economic, and political factors which contribute to the plight of the disabled cannot be altered, while appropriate application of all types of counseling, including therapeutic, is used when needed?
4) What would a curriculum based on the systems approach look like?
5) How can we (should we?) escape the placement criterion for measuring success in rehabilitation?
6) Please clarify the "systems approach" in terms of what already exists in this country and in the U.K. Is the U.K. set-up being suggested as a more appropriate model?
7) Need to discuss "disabled" jobs vs. emphasis on *any* job.
8) How does the attention to social, economic and political contexts differ from the "community organization" approach of early social work.
9) What are the background reasons (social science) for the differences, between the U.S. development of the "rehabilitation counselor" and the U.K.'s development of the "disablement resettlement officers?"
10) How do "we" present the "systems approach" to funding sources?

# A CROSS-CULTURAL APPRECIATION OF "THE CLINICAL ATTITUDE IN REHABILITATION"

**Paul Cornes**
**Senior Research Fellow, Rehabilitation Studies Unit, University of Edinburgh**

Professor Stubbins has delivered a challenging critique of our longstanding dependence on a clinical model for policy and practice in vocational rehabilitation. It begins with a reminder of what is already known about the limited effectiveness of policies based on this model and the disappointingly low dividends from a substantial investment over the years in the refinement of clinical practice and the development of new rehabilitation techniques. It concludes on a wholly constructive and practical note by advocating that achievement of the generally accepted objectives of vocational rehabilitation in a changing world may require additional measures. These should aim to ensure not only that clinical methods are applied where they will be most effective but also that alternative approaches or systems are developed to cope with other contingencies.

We are invited to consider these arguments in an evolutionary context. To make contemporary practice more effective and more relevant to changing needs, and to plan for the future, it is essential both to look back and to look ahead. Looking back helps to identify where policies or services have succeeded, where they have failed or where developments have not kept pace with changing circumstances. Looking ahead underlines the importance of policies and practices which are both adaptable and receptive to new demands. It is against this general background of social change and technological progress that Stubbins is suggesting that administrators, educators and practitioners should accord a more central role in their thinking about

the organization, operation and further development of rehabilitation services to several issues which previously may have been regarded as being of more peripheral concern.

As other commentators are far better qualified to assess Stubbins' evaluation of the clinical model as a basis for rehabilitation practice, I will not address that aspect of his monograph. My observations will concentrate on his advocacy of a systems approach to meet, at least in part, disabled people's present and future needs for specialised assistance in the labour market. In making these observations, I am mindful that social anthropology has taught us just how difficult it is to generalise from one socio-cultural setting to another—and there are many differences between Western European societies and the United States. However, cross-cultural comparisions sometimes shed new light on how our own society works. Hopefully, therefore, some analysis of British policy and services for the employment of disabled people may be of help to vocational rehabilitation personnel in the United States in reaching a decision about the part which such an approach might play in their own work.

*The Clinical Attitude in Rehabilitation* outlines the main aspects of the British vocational rehabilitation system. Stubbins has commended some aspects of such a systems approach for further consideration. I share his judgement that a systems approach has an important contribution to make in achieving the goals of rehabilitation. However, I believe that evaluation of its suitability for adoption in a different socio-cultural setting should be based on an appreciation of not only its potential but also its limitations. One way of doing this is to draw attention to the conclusions reached by recent research and official reviews of the vocational rehabilitation services in Great Britain.

The blueprint for these services was prepared by an inter-departmental committee during the Second World War (Tomlinson committee, 1943). That committee's analysis and prescriptions have shaped almost all subsequent developments: forty years on, there are few aspects of policy or provision which do not comply with the spirit, if not the letter of its guidelines.

Tomlinson recognised that most people who experience ill health or injury are, on recovery, able either to resume their former occupation or to take up some other satisfactory form of employment. It was also recognised that, where necessary, employers might help this process by assignment to lighter duties or by re-allocation to different jobs that were suited to residual skills or abilities. Such assistance has, of course, remained a feature of progressive personnel management and occupational health policies.

Tomlinson also identified a substantial number of people requiring additional assistance to help them bridge the gap between medical treatment and the point at which they could be regarded as fit for employment. A range of vocational rehabilitation services was needed to cater for their requirements. Disabled people needing to change jobs would be helped by specialist Employment Service Officers (DROs) who would assess individual capacity

and advise on the selection of suitable employment. Others would need a course of physical or mental "reconditioning" (employment rehabilitation) or vocational training before they could be placed in employment. Yet others would never be able to hold their own under competitive conditions in open employment and needed sheltered employment.

Finally, it was recognised that one other special measure was needed to secure for disabled people their full share of available employment opportunities. It was proposed that employers with less than a set proportion or "quota" of disabled people should not be allowed to engage a non-registered disabled person without an official permit to do so, and that a voluntary register of disabled people should be set up to make this scheme operable.

While this network of services has expanded over the years and has helped many disabled people to find employment, the rationale for its provision, the operation of each constituent service and the allocation of resources between them has, in most essentials, remained unchanged. However, they have not at any time achieved the overall objective of securing for disabled people a fair share of available employment opportunities and there is much evidence that they have become less effective over the years. It is true that, from time to time, officials have expressed disquiet about particular aspects (for example, the rising costs of sheltered employment or the problem of enforcing the Quota Scheme) and that evaluative research has drawn attention to ways in which individual services or co-ordination between them might be improved. On balance, though, such concern has been outweighed by the mainly reassuring tone of official reviews. These have concluded that arrangements were generally satisfactory and that major changes in practice or in the allocation of resources to services were not necessary. As recently as five years ago, a comprehensive official Development Programme (Manpower Services Commission, 1978) concluded that future needs could mostly be met by expanding or improving existing services—augmented by new initiatives to market the abilities of disabled people and to persuade employers to adopt more progressive or positive policies on the recruitment and retention of disabled workers.

By 1979, when Stubbins undertook his study of British policy and services, such confidence was beginning to crumble. There were several different reasons for this. First and foremost, the recession triggered a dramatic rise in unemployment. This added momentum to other labour market changes—the most significant of which have been a marked loss of jobs in the manufacturing sector and a substantial shedding of unskilled labour. Regrettably, these are the very areas in which most vocational rehabilitation service clients have traditionally found employment. Second, officials were confronted by results from independently conducted research which confirmed the limited and decreasing effectiveness of services; which questioned the appropriateness of traditional methods and procedures; and which concluded that the medical paradigm for policy and services should be

replaced by another which, while not overlooking clinical and behavioural aspects of clients' problems, also takes psycho-social and economic (labour market) dimensions of employment handicap into consideration. Most services had previously been quite protected from formal evaluations of this kind. Third, research underlined the extent to which other developments, including advances in medical treatment of illness or injury, had resulted in a change in the types of disablement experienced by clients. Fourth, the 1970s witnessed a dramatic transformation in the attitudes of disabled people who, with increasing awareness of the extent to which services were failing to meet their needs, changed from passive recipients of official prescriptions and "doles" into much more discerning consumers. Officials, who never relished the duty of monitoring and enforcing the Quota Scheme, took advantage of this changing climate to publicise falling compliance statistics and a marked drop in the number of people electing to register as disabled. This evidence was used to justify a proposal to abolish the Scheme (Manpower Services Commission, 1979). But officials were alone in seeking this change. Over the next two years, abolition was fiercely opposed by the disabled lobby, with strong support from trades unions and many employers. It has now been accepted by all of these interest groups that future policy will retain a legal obligation on employers to give full and fair consideration to disabled people in all matters relating to recruitment, retention and career development (Manpower Services Commission, 1981). Enforcement will be guided by a new code of practice, to which all concerned, including employers and unions, are making substantial contributions. It may be of interest that employers in Great Britain (and, indeed, elsewhere in Western Europe where similar systems are in operation) do not generally view such legal obligations as an impediment to free enterprise. It is accepted that they have a part to play in the employment of disabled people.

Recent proposals to change other aspects of services for disabled people (Manpower Services Commission, 1982) are likely to encounter similar resistance. In this instance, officials have noted that while disabled people in employment have a similar age range to the workforce as a whole and perform a representative cross-section of all kinds of work, unemployed disabled people, who comprise the clientele of vocational rehabilitation services, do not share these characteristics. The latter are generally older and more likely to lack marketable skills. They are also more likely to have disabilities that would make them hard to employ under any circumstances and to have poor work records. This evidence has led officials to conclude that most disabled clients may have more in common with other groups of long-term unemployed people than with all disabled people of working age and to propose that they are redirected from specialist services to the general Employment Service. DROs could then concentrate their attention on a much smaller caseload of recently disabled people. This proposal may appear practical and attractive, but it overlooks some important points. For example, it plays down

the part which disablement has had in leading disabled clients into situations where they share the disadvantages of long-term unemployment with other groups. Disabled clients in this category are not only handicapped by their disabilities but also by the ineffectiveness of the very services set up to help them.

Although policy makers did not anticipate the gradual accumulation over the years of a large pool of disabled people who have not benefitted from specialist services, the disabled lobby is well aware that Tomlinson's package of services has these shortcomings. It has also come to recognise that, in the present economic climate, significant gains in employment opportunities are unlikely to be achieved in the open employment sector. While they have expressed support for recent decisions to retain a Quota Scheme, to enhance the effectiveness of existing rehabilitation services, to improve guidance to employers and to develop more effective marketing of disabled job seekers, disabled people may be disinclined to place any reliance on the other changes currently envisaged. They favour, again with much support from many other quarters, alternative policies to stimulate demand for disabled workers. The main objectives for such policies would be to expand provision for sheltered and other forms of subsidised employment and to remove the barriers which presently prevent disabled people from securing a reasonable share of part-time jobs. Thus British policy and services may in future come to place much more rather than less reliance on systems approaches.

Although British experience may suggest that a systems approach is neither a panacea nor an easy option, the difficulties encountered in making it work have generally tended to reinforce rather than shake convictions about the need for such an approach. Similar conclusions have been reached in other countries. A recent review of vocational rehabilitation in the member states of the European Economic Community (Croxen, 1982) confirms that most now acknowledge that such an approach is an essential element in policies and programmes for the social integration of handicapped people. This policy orientation has been shaped by two main considerations. Firstly, there is a growing acceptance that employment handicap is often much less closely related to impairment or disability than to attitudinal, social and environmental factors. Secondly, it is increasingly recognised that vocational rehabilitation services should aim to do more than bridge the gap between medical services and the labour market. They must become instruments of social as well as economic policy.

Stubbins maintains that some if not all of the circumstances which have promoted a change of climate in Western Europe are to be found in the United States, and that the time has come to give more serious consideration to the part that similar systems approaches might play in making American vocational rehabilitation services more effective. It is held that, despite its undoubted successes over the years, the clinical model has certain limitations in conception and execution, and that contemporary practice would benefit

not only from attempts to ensure a better pay-off of clinical methods but also from new initiatives based on a wider conception of the causes of employment handicap. It is also held that future practice may need to be developed (and justified) as much as an aspect of social policy as on economic grounds.

Accommodating such changes will inevitably make some new demands on rehabilitation practitioners, educators and administrators. It is therefore important to establish the bounds within which Stubbins' proposals for the further development of vocational rehabilitation services are expected to be achieved. Three of the main issues involved are concern over the compatibility of clinical and systems approaches; the form that an American systems approach might assume and the implications of systems approaches for rehabilitation counseling practice.

Although clinical and systems approches have been presented as alternatives for debate, it does not follow that they are necessarily conflicting options for practice or policy. Indeed, compatibility between these approaches is discernible in most vocational rehabilitation services. For example, while the principal orientation of service delivery in the United States is clinical, systems approaches are not neglected. Stubbins cites the Targeted Jobs Tax Credit and Projects with Industry schemes as examples of the latter approach, and there may well be others. In contrast, examples like the British and West German quota schemes show that service delivery in Western Europe places more emphasis on statutory instruments to stimulate labour market demand for disabled workers. But such concern does not mean that systems approaches are pursued without recourse to clinical methods, as current developments in the British employment rehabilitation service exemplify. Following a recent evaluation (Cornes, 1982), several new initiatives are being taken to make better use of professional expertise and to develop assessment techniques and rehabilitation methods, in many instances drawing on American research and professional practices. Differences between vocational rehabilitation services are therefore mainly attributable to the balance struck between clinical and systems approaches rather than their reliance on conflicting models.

Even so, in the absence of detailed description of what an American systems approach might look like, it could be considered that adoption or adaptation of one or more of the European approaches is being advocated. However, as Stubbins recognises, there are several reasons why such a simplistic solution might not work. For instance, if these approaches were so self-evidently suitable, it is likely that they would already have been tried out. This has not happened because it is recognised that particular solutions are at least to some extent appropriate to, or dependent on, certain sociocultural, political and economic conditions. Thus, while invalid co-operatives may flourish in the socialist economy of Poland, which guarantees them monopolies over the production of certain goods, it is unlikely that they would fare as well under more competitive market conditions. In the same

way, it is arguable that vocational rehabilitation policies and programmes in West Germany and Great Britain are similarly dependent on the social insurance and welfare state systems found in these countries.

But this is not an argument against paying more attention to the development of systems approaches in the United States. It is, rather, a *caveat* against adopting approaches which are not sympathetically rooted in American social, political and economic institutions. A systems approach does not beg a particular solution. It merely requires that attention is directed to the labour market context within which vocational rehabilitation services operate and emphasises the part that measures taken at a societal rather than at an individual level have to play in reducing or removing employment handicaps experienced by people with disabilities. In an American context, therefore, a systems approach would be exemplified by any socially and politically acceptable action taken to improve the rehabilitation and return to work of disabled citizens arising from instances where it is acknowledged that they share common problems, to which the most appropriate or effective solutions are to be found in interventions at a societal rather than at an individual level.

This definition may help to clarify the implications of Stubbins' monograph for rehabilitation counseling practice. Counselors are generally accustomed, both in everyday involvement with clients and in consideration of professional matters, to working and thinking in an individual mode. Given this prevailing orientation, it would not be too surprising if some counselors perceive a critique of the clinical model as criticism of their professional activities or even as an argument for abandoning tried and tested methods in favour of such relatively untried and untested alternatives as advocacy or social activism on behalf of people with disabilities. Seen only in this light, particularly at a time when vocational rehabilitation services are already quite closely monitored, a critique of the clinical model could cause practitioners to close ranks or to take some other steps to re-affirm traditional professional values and principles of practice. But such "collective denial" may not be warranted. Stubbins' case is not so much directed at individual practitioners as to the profession as a whole. The limitations of the clinical model which concern him most are not those which suggest that existing practices and procedures can be made more effective. He is more concerned with those which underline the extent to which a clinical model has encouraged thinking about the further development of practice to become so focused on problems associated with service delivery to individual clients that the potential of other possibilities to enhance the effectiveness of counselor/client interactions has not been fully explored. The exploration and evaluation of these other options for vocational rehabilitation policy and practice may not require individual practitioners to make any immediate changes to established working practices. The initial challenge is to the profession as a whole to ensure that some practitioners, educators and administrators are given oppor-

tunities to study the social, economic and political contexts of professional practice with a view not only to the improvement of existing approaches but also to the identification and development of effective alternatives.

Stubbins clearly believes that, to attain the objectives of vocational rehabilitation in a changing world, we must be prepared to make some changes in our methods and to revise our thinking about the role of vocational rehabilitation in society. Although it may be tempting to view his monograph as futuristic or, to the extent that it questions professional orthodoxy, even heretical, it really has neither of these qualities. While I do not agree with him on every point, I share his conviction that a clinical model may have clouded our vision of the art of the possible and that the efficiency and effectiveness of vocational rehabilitation, both today and in future, depends on the extent to which clinical methods are complemented by other approaches. *The Clinical Attitude in Rehabilitation* raises issues that cannot be ducked. It will influence our agendas for thought and action for many years to come.

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**Acknowledgement** I was delighted to accept the invitation to participate in the programme of meetings and discussions which the World Rehabilitation Fund Inc. organised to promote dissemination and utilization of Stubbins' monograph on *The Clinical Attitude in Rehabilitation*. I therefore wish to express my gratitude to the World Rehabilitation Fund both for the invitation to do so and for the support under the International Exchange of Experts and Information programme which made my visit possible.

## Commentary on Joseph Stubbins' Paper and Monograph on the Clinical Model in Rehabilitation and Some Alternatives

Professor Stubbins paper and his monograph prepared for the World Rehabilitation Fund present us with a wide array of intriguing and challenging ideas for discussion. It is a privilege to be able to respond with some thoughts that have been engendered by his presentation.

In the first place, it seems to me that his description of the vocational rehabilitation system in the United States is far too negative. While hyperbole may be useful to direct attention to a problem area and generate concern it does not necessarily reveal the facts. Our vocational rehabilitation system never "promised" to be the perfect solution to all the problems of all disabled people, despite some grandiosity apparent at fund-raising times. What it has set out to do, that is to return a significant number of disabled persons to paid (or other productive) employment, it has done with considerable success. That its success has been less than total does not seem to me to be a valid criticism of a system that never aspired to this goal in the first place.

In any event, Stubbins consistently presents an implied (and sometimes explicit) negative comparison of the U.S. system vis-a-vis those of other countries, notably that of Great Britain. But there are no data presented to support his assertion in terms of cross-cultural evaluation of outcomes, only his own observations. Lacking are comparative studies of the satisfactoriness of different systems as measured by numbers of job placements or other employment goals. Nor are there any comparative studies of client, professional, or public satisfaction with different systems. In fact, some of the observations of the British system which he himself reports in his monograph raise some doubts about its desirability, as I will note later on.

Certainly one of the most useful lessons of Stubbins' paper is its insistence on the value of continuing review of our professional beliefs, behaviors and goals. One extension of his presentation is that our system would be improved if its *vocational* rehabilitation goal were replaced by a more generic rehabilitation goal—in the sense of the National Rehabilitation Association definition of rehabilitation as the process of helping handicapped people reach the maximum total functioning of which they are capable.

The concept is interesting. It might foster the development of a coherent national policy toward disability and disabled people. On the other hand, whether this is practical, or manageable, or even necessary, is moot. The mere size of a "total" rehabilitation system would be awesome and (to some) alarming, as it would have to encompass a whole host of currently parallel systems such as education, medicine, social service and recreation. A more reasonable approach seems to be the current concept of a vocational rehabilitation system which is defined in terms of the goal of "paid employment." This allows for the development of service programs which, having more

specific goals, are more easily held accountable by their consumers and the general public, a point for which disabled persons themselves have fought.

Traditionally in the U.S. the methods used to make our vocational rehabilitation mission operational call for the provision of clinical, or individual, services as well as other support services some of which may be directed at environmental manipulation. The rationale for this approach is that where disabled persons are unable to function at their maximum we can (1) strengthen their own ability to cope with and overcome their limitations through clinical methods or (2) effect changes in the environment through protective and special services that result in minimizing the effect of their limitations. Stubbins asserts that we have erred by over-emphasizing the clinical approach and calls for a drastic re-alignment of our priorities in favor of what he calls a systems approach.

This proposal presents several problems. Among them is the fact that his view does not recognize that systems can be changed in many ways. One of these is by changing the individuals who interact with the systems, so that rehabilitated clients become their own change agents. It is, of course, a matter of philosophy and belief that systems can be changed as well by new experiences as by fiat. It is based on the value judgement that it is preferable to teach people how to catch their own fish, rather than to give them a ration of fish. The position is defensible, but no more provable than is its opposite.

His paper also minimizes, essentially ignores, the fact that rehabilitation counselors have never been "clinicians" as much as they are counselor/coordinators. The *ideal* rehabilitation counselor has always been concerned with a holistic approach to the disabled client's vocational rehabilitation problem, and has traditionally discussed, referred for, and sometimes paid for, any service needed to help that client achieve a rehabilitated status, particularly when lack of such service reduces the client's chances to achieve the goal of paid employment. One has to wonder who the counselors (and their educators) are that Stubbins has talked to. Somehow they do not seem to match the model that many of us have seen in action.

Let us suppose for the moment that major shift in emphasis that Stubbins proposes does occur. Could we really anticipate any better results than we now experience as he claims would be the case? An effort to respond to that question only raises further questions.

For example, one measure of the efficiency of a social agency is its accuracy in responding to the needs of its constituents. Granting at least partial validity to the claims of representation raised periodically by various disability groups, nevertheless, our record in this country seems relatively good. While no one group is entirely satisfied with its portion of the rehabilitation "pie," at least we do recognize and have programs for almost every imaginable disability group, from the orthopedically disabled to the learning disabled. Stubbins does not address this point. Certainly this is one area where cross-cultural *research* would be in order to provide a factual answer to the

question of how we compare to other countries in this vital respect.

One could also question whether the delivery of services to meet assessed needs would really be improved. This prospect is certainly not established by the facts or the logic of Stubbins' paper.

For example, his own observations of the process of vocational rehabilitation in Britain include instances of problems that are disturbingly familiar to us, and some that seem (given our value system) perhaps worse than ours.

From his British visit he notes (page 20) that clients are viewed in "terms of immediate placeability" and that it is "easy" for the British DRO's to distinguish between the employable and the unemployable, a discrimination task that has perennially challenged their US counterparts who may be less ready to make such a serious judgement on limited data. Further, on page 21 he notes a focus on clients that are easy to place, "creaming," and an acceptance of a genetic basis for behavior that sounds too limiting to many of us. On page 22 he notes that the interviews conducted by the DRO's seem too brief to allow for an accurate expression of client needs, and continues, on page 23, to a statement that DRO's tend to view clients in a paternalistic light. Finally, on page 26 he talks about the decline in ERC graduates employed over a 16 year period from 51 to 21 percent.

Assuredly looking at the experience of other countries as Professor Stubbins did in great Britain can be very enlightening. Thus a review of Ruth Purtilo's monograph on health care and rehabilitation in Sweden seemed to have potential. Her "Lessons from Sweden" reveal similarly distressing problems as presented in comments from clients in a country where the "systems" approach is even more advanced than in Great Britain. On page 29 there is a discussion of their feeling of loss of freedom, and page 37 recounts instances of the adversary mentality engendered by the Swedish approach. On page 38 there is a human interest story about disincentives to rehabilitation in Sweden that could be shifted to an American locale without any loss in the translation, except that it is perhaps even more extreme than our experience.

It is interesting to speculate about what would happen in a world where the systems available to meet clients' needs really worked. Would we counselors, as some have suggested, finally be superfluous? Experience and logic suggest that even in this utopia that would not be the case. Even in a "perfect" world persons (including disabled persons) could be troubled with career decisions. In fact, without being hampered by environmental barriers, the issue of expanded vocational choice for a disabled person might as the range of available vocational options enlarges become larger not less. In utopia, career problems of disabled persons will not disappear; they will just become more like those facing the non-disabled.

Assuming a major shift in policy resulting in a "systems" as opposed to a "clinical" approach to rehabilitation raises some additional questions. Who would perform the jobs needed to be done, and what would be the nature of their work? For example, Stubbins indicates a need for the disabled to increase

their organization for their own benefit, and sees that rehabilitation counselors may be needed as a "necessary evil" to help in this task. But one may question whether this is a proper role for a rehabilitation counselor. Is it not perhaps better suited for one trained in the social work specialty of community organization? Similarly, there has been, is, and certainly will continue to be a need to develop legislation for the benefit of disabled persons. Yet the drafting of legislation seems to be best left to those who are equipped to do it; the rehabilitation counselor's role should be, as it is now, to recognize the need for legislative change and campaign to see that needed changes are effected.

In summary, Professor Stubbins' paper stimulates us by challenging our traditional view of vocational rehabilitation and suggesting a different model which emphasizes the systems approach. I assert that the proper role for a rehabilitation counselor is one which involves the counselor in a combination of "clinical" and "systems" activities. Ideally the choice of mode is a response to the demands of whatever situation the counselor is in. Such a view avoids what seems to me to be the major problem with Professor Stubbins' approach, that is a sort of "all or nothing" view of rehabilitation. Purtilo discusses this pitfall in her monograph, and quotes both Tawney and Fuchs (p. 41) on the same topic when they both discuss the equal error of refusing to admit society's role in handicapping the disabled or completely denying individuals' responsibility for their own status.

In contrast, what seems to be needed is the variable allocation of resources to promote social change and provide individual services with priorities and programs reflecting changing times. This would allow what is needed to improve vocational rehabilitation's "batting average"; (1) a flexible policy which may still define the goal of the vocational rehabilitation system as promotion of maximum paid employment, but (2) which really stresses the identification of all barriers restricting achievement of that goal and (3) devotes resources to clinical services *and* advocacy, community organization and legislation as determined by need.

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**Patricia Livingston, Ph.D.**
**(New York University)**
**March 17, 1983**

## Comments on Joseph Stubbins' material on The Clinical Model in Vocational Rehabilitation

I agree with many of Dr. Stubbins' conclusions. I am sympathetic with his notion that the clinical approach has been overworked and that a more broadly based approach to rehabilitation is needed. I am grateful to Dr. Stubbins for informing me about what is wrong with the clinical approach. I have been looking at rehabilitation from a point of view which is essentially nonclinical but I never realized it. My approach certainly make me sympathetic with a study which criticizes the clinical model. My problem is that I agree with his conclusions, but I suspect for quite different, separate, and distinct reasons.

I believe vocational rehabilitation to be an economically viable program. Dr. Stubbins and I agree that it has been sold to the Congress and to the public, as an economically viable program, and we both agree that the motives of some of the advocates are suspect, and the data they use to base their conclusions are quite deficient. But although we agree on these fundamentals, I suspect that we part company at this point.

I believe that we need better selection techniques in order to serve appropriate clients. I believe that we need better measurement devices to prove the economic viability of the program and to measure its economic efficiency. I do not believe that we should abandon the goal of an economically efficient program.

He believes that we should redefine the goals so as to include nonjobs as jobs and that we should abandon the goal of seeking labor market jobs for the disabled in light of current unemployment levels. I respectfully disagree.

Some of our differences are purely semantic. He criticizes "creaming," for example. I am not sure I am against creaming, but surely it depends on what is meant by the use of that term. I am against serving clients who would return to the labor market, with or without the services offered by vocational rehabilitation. If that is what is meant by creaming, I join with Dr. Stubbins and others as being opposed to this needless proffering of services without result. However, I am not against serving, first, the clients who have the best chances of returning to the labor market. That selection procedure makes a great deal of sense from an efficiency point of view. I also recognize that it may be contrary to some people's notion of equity, but I am willing to make reasonable accommodations to whatever the appropriate equity constraints are.

Dr. Stubbins criticizes and disparages the social security disability insurance rehabilitation program. But the Beneficiary Rehabilitation Program is not to be dismissed out of hand. Extensive analyses of the program have exposed the difficulties. In part, the problems of the program stem from the application of the clinical model that Dr. Stubbins criticizes, and I believe that model was particularly inappropriate in the Beneficiary Rehabilitation Pro-

gram. But this is not to say that the program did not work. It was an ideal situation to test some measures of economic efficiency. It was an ideal test of the entire vocational rehabilitation program. The objective was to get people off the beneficiary roles. Hence, the measures of benefits were unambiguous. Also, the selection criteria, although ideal conceptually, proved difficult to enforce administratively. The vocational rehabilitation program was not to take people unless it could be shown that there was a reasonable prospect of rehabilitating them, and that the amount of benefits that would be saved would be equivalent to or greater than the cost of rehabilitation.

The real problem was that nobody took the program seriously until it was threatened, and by that time it was too late to save it. The Beneficiary Rehabilitation Program became an early casualty of the economy measures of the new administration.

But the tests of the Beneficiary Rehabilitation Program need not be the same as the tests for the general rehabilitation program. This is especially true of rehabilitation of the severely mentally retarded persons, for example. Here Dr. Stubbins and I again come to an agreement from different approaches and for quite different reasons. I do not believe that we should abandon the idea of efficiency tests, even in the case of severely disabled persons, but I would argue that there is real economic value in rehabilitating a person, even though that person may not return to the labor market. When we talk about severely mentally retarded persons, for example, the restoration of these people to a life of independent living, possibly their deinstitutionalization, certainly has "utility," certainly these are values that society is willing to pay for. At least, they are values that the family of mentally retarded persons are willing to pay for, and we need not accomplish very large changes in function in order to garner economic benefits. In short, it is a mistake to make *money* savings the sole criteria for *economic* gain. It is necessary also to look at general increases in utility and these are where we need objective measures.

I can handle many of these items without coping with any of the moral issues involved, or considering the life of the disabled as a form of social pathology. In fact, many handicapped persons do view professionals in rehabilitation as feeding off public funds which can be better used to support the independent living movement and self-help ventures. Much more attention should be paid to independent living, anti-discrimination legislation, job accommodations and other types of adjustments which may make paths to the labor market easier for those persons who are disabled.

Who can quarrel with Dr. Stubbins' assertion that the problems of disability are generated by societal structures, and therefore solutions are to be sought at the social level. It seems to me that there are many paths to the promised land. We must work on systems of prevention, we must work on compensating people for certain types of disability and we must work on rehabilitation. I think I understand the systems approach. I do not understand

that is where we ought to have been. Counselors play roles in counseling, guidance and placement of persons that are disabled. I despair of attending meetings of rehabilitation counselors where the conclusion is everyone should go out and reform the economy. We live in a world where there is a division of labor, and reforming the economy is not the job of the rehabilitation counselors. I do think we should be concerned with improving the administration of 504, or trying to unravel the terrible complexities of job placement in light of union-management restrictions, but counselors' primary job is to do what they can to make a person job ready and to get him out into the labor market. If that is a clinical model, to that extend, I do not suppose I have great problems with it. If on the other hand, I am going to improve the personality of the person and work on his psyche to the exclusion of getting him a job, then I depart.

I have to admit that one of my problems is that in my use of a systems approach to understand the problems of rehabilitation, I have often regarded what the counselor does as being in a sort of a "black box" and have not penetrated it in any manner. Consequently, if the counselors do not administer the correct mix of services that they should, or that an experienced rehabilitation psychologist tells me that they should, then I cannot quarrel. But I do think that it is necessary to understand that somewhere, somebody along the line, has to lay hands on persons who are outside the labor market and provide a mix of services to them. We must never lose sight of the fact that a part of the mystique of rehabilitation and part of its efficiency lies in the fact that the rehabilitation counselor has been able to command a wide range of resources, be they educational, physical medicine, counseling, guidance or placement. He has never been restricted to any one modality, and I always thought that this was one of its virtues. If we have strayed too far along one particular path, we ought to bring the engine back, but this is not to say that it ought to be abandoned in its entirety.

**Monroe Berkowitz**
**(New York University**
**March 17, 1983)**

## The Vocational Rehabilitation System

Vocational rehabilitation has been around for a relatively long time, at least as far as social service programs go. Time frequently translates into tradition. Tradition is important in that it preserves values and sorts out the enduring from the fadish. It conserves what is best as time evolves. However, tradition that goes unquestioned or refuses to admit innovation, merely serves to chain the present and future to the bondage of the past. Professor Stubbins challenges us to face tradition squarely and to account for what we do today on the basis of today's needs and knowledge, rather than on yesterday's. His challenge is clear and does not allow us to dodge the issue of relevance. Whether we agree with his rationale or proferred solution is less important than that we face forthrightly his call for a re-analysis of what vocational rehabilitation is all about.

Professor Stubbins early on points out the significance of the values that rehabilitation practitioners ascribe to. These values give us our motivation and will do something significant for our clients and society. Without values we lose our purpose. Values are tricky to deal with. They are not researchable. There is no one "right" set of values that will lead rehabilitation practitioners to a standard solution for overcoming all disabling situations. However, without values we can not expect to accomplish anything. It is always timely to clarify our values. As individuals we can re-affirm our own sense of mission and worth and as a profession we can inspire each other by questioning how we communicate our values to our clients and to society in general. We must ask ourselves if we really mean what we say or if what we do somehow adds to or detracts from our claim of social service.

I believe, as Professor Stubbins suggests, that we have allowed the technology of clinical psychology to erode our value for the self-worth and independence of our clients. My view of it is that we have substituted the value people with disabilities have for becoming vocationally competent with the value derived from our psychological inclinations for people to achieve our understanding of psychological competence. Unfortunately, there is a different view of what psychological competence is for every different psychological school of thought that exists. Our clients' vocational needs get lost in our own need to transform them into the ideal psychological models prescribed by our pet theories. I'm not advocating, and I'm sure Professor Stubbins does not either, that we renounce our psychological heritage. Psychology has taught us much about how people learn and change. This is a valuable technology to use to help our clients attain their vocational goals.

I find it necessary to emphasize the term vocational rehabilitation. I know Professor Stubbins chose to use this term interchangeably with rehabilitation. This was somewhat confusing to me since it seemed that in most instances Professor Stubbins was writing about the state/federal system of vocational rehabilitation. Yet the clinical model described by him does not fit

my perception of what is practiced in that system by the professionals employed there. As one example, Professor Stubbins concluding his monograph intimates that rehabilitation clinicians would resort to "catharsis, skillful listening or relaxation therapy" to counteract the anger of clients. I do not believe that very many agency rehabilitation counselors use these techniques to any great degree. This kind of clinical practice might be found in the role of rehabilitation psychologist which I believe is a distinct one from that of counselor. Professor Stubbins does not make this distinction as clearly.

It seems the view of vocational rehabilitation presented by Professor Stubbins resembles more the education programs offered by universities for training rehabilitation counselors. In universities the psychological/clinical model appears more distinctly. Also, since universities are more likely to contribute to research, it is not surprising that rehabilitation research appears technique-oriented and bound to the clinical model. More discussion could be directed at the role of the university system in promoting the continued reliance on clinical and individual approaches. A more important reason for being precise about our use of the term vocational rehabilitation is that it could serve as the boundary for defining the scope of the system of publicly supported rehabilitation in the United States. A case could be made that the reason our system seems to have developed problems with placement is that we have lost our moorings in the vocational orientation that was the mandate of the state/federal system. Over the years policies have changed regularly to include a variety of populations which traditionally have had a difficult time in the labor market for a variety of reasons, one of which can be attributed to employer discrimination. Recently, we have included independent living in scope of services and expected outcomes of the vocational rehabilitation system. Independent living is an important goal but it is a different goal from the placement goal expected of the state/federal system. Professor Stubbins suggests our policy of vocational rehabilitation has evolved from the clinical method. Perhaps another interpretation of these frequent policy shifts is that they result from political pressure of special interest groups. Any discussion of policies and systems can not ignore the obvious impact of politics.

To return to the major point, vocational rehabilitation as a system might achieve its labor market expectations if it recognized that the labor market was the system which not only defines the outcome, successful placement, but also suggests the types of services necessary to achieve the outcome. It is not important to help people with disabilities get into the economy as Professor Stubbins indicates, but into the work force. People with disabilities are already involved in the economy, but not in ways we most value. Those ways, of course, are as self-supporting workers or employers. The labor market requires we tailor the technology of our services to employers and clients because these two groups are the principle actors in the market. As vocational rehabilitation professionals lower the costs of job searching and hiring for clients and employers, they will be recognized as valuable social contributors.

All that counselors do can be evaluated in terms of how costs are decreased for clients and employers alike. This does not discount the clinical method but applies it as a tool as needed. Counseling to develop goals, increase motivation, build self-confidence can all be justified for eventual participation in the labor market.

In summary, I agree with Professor Stubbins conclusion that the vocational rehabilitation system has recently not been as effective in developing quality placements as it could be. However, I do not feel we need to change our ideology from a clinical individual approach to a system approach. I agree with him that a blending of the individual and system approaches is useful. However, I would focus on the labor market as the crucial system if the problem we are concerned about is placement. If we wish to take the state/federal system to task for not being as effective in this and other aspects of rehabilitation, then we should consider broadening the goals of the system and providing a similar expansion of resources. Let us be careful of adding additional systems and processes to what we call vocational rehabilitation if we want to primarily achieve a better integration of people with disabilities into the mainstream of our work force.

**David Vandergoot**
**(New York University**
**March 17, 1983)**

## The Clinical Attitude in Rehabilitation and Alternatives...A Reaction

As a former member of the National Council on the Handicapped, I've been concerned about various policy questions and system concerns. Thus Dr. Stubbins' monograph and his general writings collide with and bounce off of this checkered career and my personal experiences in the field. Much of what he has to say I support—on the other hand—I have a few obligatory reservations. In my comments I'll attempt to make clear both my concurrence and my personal cautions or outright disagreement.

Stubbins, Hahn, DeJong and others have called into question the dominant clinical attitude in rehabilitation service in the U.S. They see this essentially medical model as an incomplete or narrow approach to overcoming the personal, social, and economic problems confronting people with disabilities. While they would not abandon the clinical approach, they clearly would advocate that counselors and others in rehabilitation practice become more cosmopolitan in their perspective. As Stubbins has said, "the romantic individualism" of counseling and psychotherapy must be balanced by a social/ecological perspective...one which appreciates that counselor and client operate within social, economic, and organizational realities. In Stubbins view, the individual's circumstances are not purely matters of individual responsibility. Will, motivation, and 'character' may not be sufficient to overcome the forces of structural unemployment and/or bias and prejudice on the part of employers for example.

We must also acknowledge that this is not the first time that this disequilibrium has been revealed and brought to our attention. In the 1976 publication, *Whither Rehabilitation Education: A State of the Art Report*, the author W. Alfred McCauley states, "Perhaps the practice of rehabilitation counseling should turn to the development and application of skills to make social systems more accommodating toward the handicapped."

Levitan and Taggart in *Alternatives in Rehabilitating the Handicapped* report that increasing injections of professional expertise, new techniques and even legal mandates have not significantly improved the job placement batting average. Stubbins admonishes us by saying that V.R. is creating a pool of well diagnosed and counseled persons without jobs or any sense of life purpose. Basically we are still pulling people out of the swamp one by one; rather than draining the swamp!

As Hahn has made clear, our interventions flow logically from our definition of the problem. The clinical perspective essentially assumes that the client's problems reside within his/her limitations, disability, or pathology rather than resulting from his/her devalued status in a highly competitive market place. Stubbins is correct in noting that it was the activism of disabled persons which forced us to redefine their status from one of deviance to one of disadvantage. A disability advocate, Finkelstein has asserted that rehabili-

tation practitioners live off the unhappy circumstances in which disabled persons find themselves and then compound the injustice by all too frequently playing, "blame the victims," i.e., the cause of the client's social, personal and economic problems result from his/her inactivity, lack of social skills, lack of drive or motivation, physical limitations, or "unpleasant appearance."

I have heard many disabled persons claim that one of the major obstacles they had to overcome in their rehabilitation was the physician, therapist, and counselor sent to treat or counsel them.

Drama sometimes makes this point much more forcefully than academic texts. In Brian Clark's play, "Whose Life is it Anyway?" the newly paralyzed sculptor, Ken, resists the medication prescribed by his physicians with these words, "Oh, I shall get the tablet, but it's you that needs the tranquilizing, I don't. You watched me disturbed, worried even perhaps, because you can't do anything for me—nothing that really matters. I'm paralyzed and *you're impotent*. The only thing you can do is to stop me disturbing you. So I get the tablet and you get the tranquility."

Thus, we need to appreciate our clinical limitations—but is the answer to emulate Britain's disabled resettlement officer? DRO's are regarded in England in much the same way as Employment Services counselors are regarded in this country, i.e., ineffective, untrained, and harried.

Sources in England assert that DRO's generally serve manual workers. Skilled or educated individuals avoid them precisely because they underestimate their client's potential. Apparently some British clients would prefer to be assisted by an individual who had a few more "romantic illusions."

Whether in Great Britain or America, the counselor's attitudes and values are shared by their respective cultures. Stubbins reports, for example, that DRO's easily accept class stratification, a deterministic view of life and Social Darwinism. All of which may be seen as rather "natural" to them.

The "evidence" would seem to suggest that DRO's find the class distinctions of the British society as "natural" in the same manner that some American rehab. counselors feel it is "natural" to devalue and underestimate the disabled or "natural" to believe that accessibility requirements may be unrealistic and too expensive as a general social policy.

I would assert, however, that we are in debt to Joe Stubbins for his monograph description of the DRO's *lack* of psychological and sociological insights. Apparently concepts such as reaction to trauma, coping, and personal adjustment are unfamiliar to the DRO since as Stubbins says, "much of this knowledge exists beyond the realm of common sense."

Stubbins puts it so well:

> It was clear that the DRO lacked a suitable repertoire of conceptual and diagnostic tools with which to prognosticate the client's potential for functioning at a higher vocational level and the means

of guiding and motivating the client to reach that greater potential (p. 24).

Counselors need not be so preoccupied with maximizing potential and upward mobility if they generally hold to a deterministic view of life in which one's class position generally dictates one's future.

Oh, but help is on the way for the uninformed DRO for Stubbins tells us, "The more recent emphasis in the direction of work adjustment training seemed to coincide with the recognition that most of the physically disabled clients had a variety of *psychosocial* problems which were as *troublesome* as their physical impairments" (p. 26, emphasis added).

Dr. Stubbins, it seems to me makes an excellent case for upgrading the professional preparation of DRO's. Perhaps American rehabilitation counselor educators have something to share as regards enhancing the psychological sophistication of the DRO's. In turn we might learn more about employer development, and pragmatic approaches to job placement.

A minor side regarding the quota system approach. I would simply note that one's preferred approach in terms of reducing discrimination and promoting employment also reflects our cultural and social views. Quota systems have been put in place in countries which are much smaller and more homogeneous than in the U.S. My personal forecast, subject to modification through empirical study, is that U.S. policymakers and employer groups would resist quotas for disabled persons, in part because we are a much more pluralistic society and these policymakers and employers would fear that quotas might then be established for a variety of other groups, i.e., women, Native Americans, Hispanics, etc.

I certainly support the study of various policy options. Indeed quota systems are a legitimate area of cross national study. However, let us also explore the policy implications of a National Health Insurance scheme; let us learn more about the strengths and weaknesses of Ontario's government based approach to worker's compensation rehabilitation and let us study quite earnestly the disincentive dilemma in our own approach to income maintenance, social services, and rehabilitation.

As regards rehabilitation research, I would agree that the domination of psychological and educational research methods have sometimes resulted in narrow, trivial research while ignoring weighty social, economic, and political lines of inquiry. I note that only this year the NIHR awarded at least one economically oriented research project. Dr. Stubbins and I would both encourage rehabilitation researchers to broaden their scope and would also urge that we induct proven economists, political scientists, and policy analysts into our field. Disability and rehabilitation is a multi-billion dollar neglected enterprise. The number of citations one may find in the literature by qualified social scientists is discouragingly low.

Hopefully our discussion today will also touch upon the respective role of undergraduate, master's and doctoral level study in rehabilitation counsel-

ing. It seems to me that we need to assure that our M.A. candidates have a solid undergraduate education in the social sciences of economics, sociology, political science, and psychology. At the M.A. level the focus should be on the values, skills, and knowledge necessary for entrance into the profession, i.e., counseling, medical-social-psychological aspects, labor economics, vocational assessment and career development, and job placement.

By the way there is some research evidence that the best thing graduate education does—and it's no minor achievement—is to inculcate professional values and standards.

Our doctoral studies need to prepare some individuals for clinical application, i.e., rehabilitation psychology or counseling psychology while other students have the opportunity to pursue doctoral studies and careers in administration and policy research in rehabilitation, health and human services.

In conclusion it seems to me the fault lies not with the clinical model alone but perhaps in our asymmetrical strategy—a singular, incomplete, specialized clinical response to the consequences of disability and devaluation. Does high level structural unemployment really dictate as Dr. Stubbins asserts that "it makes no sense to invest in vocational rehabilitation." Are we really to abandon the clinical approach in favor of benign faith that the political and public policy process will forge an equitable social order. Will a self-proclaimed conservative administration and a divided Congress give us the opportunity structure, the programs, the imperative of the quota system when decidedly more liberal Presidents could not achieve a full employment policy or a national health insurance scheme?

The answer it seems to me is not to abandon our clinical, counseling, and individualized service heritage while we become more aware, more sophisticated and more effective in our ecological response. Our strategies need more integrity—in both the ethical/moral sense and the symmetrical sense.

The need for policy debate and initiative is clear—if not urgent—but are we to pursue a single line of offense, i.e., policy and ecological initiatives at the expense of individualized services? I would observe that the debate between clinical and ecological approaches may simply reveal a false dichotomy. Must we choose one or the other? Apparently not according to Stubbins who writes in his World Rehabilitation fund monograph:

> Clearly, I feel there is a need for psychosocial services for individuals though it might have seemed otherwise in this chapter. But there is also a need to recognize the limitations of clinical methods and to give more attention to policies and programs directed at redesigning the social and occupational life for the benefit of disabled persons (p. 18).

and later,

> Clinical and social systems are not necessarily mutually exclusive

and we should try to appreciate the merits of each separately (p. 29).

These social/economic times do try our souls and we are indebted to Jo-Stubbins for forcing this dialectic examination of our belief system. He aised troublesome questions, but he's also raised the level of discourse.

**Donald Galvin**
**(Washington, D.C.**
**March 20, 1983)**

## Rehabilitation
## An Historical Perspective

The work of Joseph Stubbins deals vocational rehabilitation a stunning blow. He suggests that the program may have reached the limits of its ability to do good, and he wonders if we should not cast about for alternatives to the program. Failure to find these alternatives may lead to the obsolescence of the program and of those who administer, counsel, and oversee the program at both the state and federal levels of government. What can a historian add to Professor Stubbins' very perceptive critique?

Perhaps a historian should begin with Dr. Stubbins' statement that, "We believe disabled people are arranged pretty closely to where they deserve to be especially after rehabilitation counselling." I wonder if that statement really reflects the attitude of rehabilitation counselors. It seems to me that they, like social workers, have a desire to be an agent of change; they want to see good results follow from their actions. So I suspect that the counselors do not feel that the disabled are in any way flawed. Instead, they despair over their ability to be of help. They feel that the system, not the disabled, has failed. There is, in fact, a historical rhythm to these feelings.

At certain times society looks at its problems with optimism and romantic philosophies which argue for the perfectibility of man tend to take hold. At other times society feels the limit of its corrective actions and tends to accept the existence of problems as inevitable. This classical view of the world was prevalent in colonial times; in Jacksonian times, America was gripped by a spirit of romanticism.

Rehabilitation came into existence during a moment of optimism. In the twenties the economy was expanding and America was gaining influence over the world's affairs. In as far as this world view reached the people concerned with the lives of the disabled, it was translated into the prevailing social welfare technology of the day: casework. Through a precess of intensive interaction between a counselor and his client, the client could be adjusted and made to function in the world. The best measure of functioning in this country was employment, and employment became the variable that drove the rehabilitation program. I would emphasize that the early years of a social progaram are critical to its future development; these are the years in which the program makes choices about what sort of technology it will incorporate into its daily operation. Vocational rehabilitation, therefore, is very much a creature of the twenties, with that decade's stress on casework and with that decade's interest in making good investments with the government's money.

The survival of vocational rehabilitation in what has become a very alien world makes me wonder if Professor Stubbins is correct in talking of obsolescence. Old programs die hard. One need only witness the survival of state workers' compensation laws since 1911 to understand this fact. I doubt, therefore, that vocational rehabilitation will die a natural death. Instead, I

suspect it will project its roaring twenties view of the world far into the future.

Problems in the program go back a long way. As early as the thirties it became apparent that the emphasis on employment would cause problems for the program in its efforts to win federal and state funds. The thirties were a decade in which people began to question the efficacy of the casework approach to social welfare: what good was it to adjust clients to a world which had itself gone haywire. Programs which made employment their central objective suffered, and vocational rehabilitation was no exception. In place of the casework method, Americans began to emphasize programs which gave their benefits as a matter of right. Income maintenance through entitlement was an important legacy of the thirties. I might also suggest that depressions tend to strengthen the rationale of entitlement and that entitlement programs tend to be at-odds with programs which try to integrate their clients into the larger world. During the seventies, for example, Congress passed Sections 501-504 of the Vocational Rehabilitation Act and brought the concept of entitlement to the disabled. This action created a clash between the economic view of policy implied by vocational rehabilitation and the civil rights view of policy implied in the new amendments. The depressions of the thirties and of the seventies have, therefore, produced important challenges to vocational rehabilitation.

Drawing conclusions is a difficult act. I would argue, however, that America tends to be better at the entitlement-income maintenance programs such as SSI and DI than at the manpower-opportunity programs such as vocational rehabilitation or the United States Employment Service. We have not figured out how to change a marginal labor force participant into someone resembling a young, well-educated, and well-adjusted person. The unemployment rate can fall to zero and still leave the marginal participants behind, tucked beyond the reach of the labor market. In the case of disability, it comes as no surprise that workers' compensation, disability insurance, and supplemental security income—three generations of income maintenance programs—reach far more people than does vocational rehabilitation. They also absorb more of society's attention. These are our major disability programs, and vocational rehabilitation has become something of a sideshow. Congress makes repeated efforts to link vocational rehabilitation with the income maintenance programs, but, if one can be permitted a sweeping generalization, the links fail to take hold.

These oblique references to history bring me to two specific questions. I would raise about the Stubbins monograph. Professor Stubbins asserts the need for a systems view of disability, yet his discussion fails to consider the American disability system. It may be too much to ask vocational rehabilitation to solve the problems of income maintenance, civil rights, housing, and transportation raised by disability all on its own. Clearly, vocational rehabilitation must find its proper place within the American disability system in or-

der to facilitate a systems approach. It must learn how to coordinate its services with the larger and undoubtedly more important programs that surround it. A systems view demands that the relevant system be brought into the discussion. We are not talking about vocational rehabilitation alone.

To say that we should examine the entire American disability system begs the question of what should be done about vocational rehabilitation. We need to know how the benefits of vocational rehabilitation can be preserved and some of the shortcomings, such as an inability to accommodate the severely disabled, can be corrected. Professor Stubbins looks with some hope to the example of England. I join some of his critics in questioning the relevance of the comparison. The English have an older and more active social welfare system than we do in this country. Despite its generosity, the system tends to focus on a particular goal: employment. For this reason the English, the Dutch, and other European countries go to great lengths to place the handicapped in employment. I suspect that these efforts represent a net social cost for the economies of these countries. In this country, by way of contrast, we place much less emphasis on employment. We reserve our social welfare system for those people who are considered too old, too sick, or too burdened to participate in the private labor market. The incompatibility of our traditions limits the help that we can receive from England in reforming our disability programs.

Denied the help of the English model, we must look elsewhere. I would concentrate on the history of the vocational rehabilitation program itself. I would continue to view the program as primarily a vocational placement service for the disabled. I would not, however, allow it to languish within the confines of the clinical model so effectively critiqued by Professor Stubbins. Instead, I would point to the fact that the "science" of vocational placement has been transformed by the entrance of the postwar baby boom into the labor force. Gone are the days when following the rules guaranteed one a successful job placement, the days when proper dress, attitude, and a resume free of typographical errors brought one a good job. The days of this "white glove" approach are over and will remain over until the baby boom glut of qualified workers has been assimilated by the economy. We live in a world where informality of the type described in *What Color Is My Parachute?* dominates the field of vocational placement. This approach emphasizes adjusting the labor market ot one's innate interests and abilities instead of the other way around; it emphasizes forming contacts with prospective employers and working in groups in order to obtain employment. It also stresses that failure to find a job is not that of the job seeker alone. Jobs are scarce and serendipity (or to use a more elegant expression, rationing) plays a large role in the selection process. These insights, imprecisely expressed here, may be ones that can be brought to bear on vocational rehabilitation.

We do need to open up the clinical process, but we must also recognize

the constraints that history imposes upon us. The heritage of the nineteen twenties remains an integral part of the vocational rehabilitation program. As Professor Stubbins reminds us, we must nudge this program toward the eighties, but we must do so gently, mindful of the fact that programs lack the ability to transcend their historical identities.

**Edward D. Berkowitz**
**(Washington, D.C.**
**March 20, 1983)**

## The Power In Positive Rehabilitation

I concur with Dr. Stubbins' observation that all is not well in rehabilitation. But what of his diagnosis and prescription?

The diagnosis seems to be that rehabilitation concentrates clinically on clients. The prescription seems to be that what the counselor should be concerned with ought to occur at every level of the social system.

But the concept "system" is not transparent and may indeed be opaque. I shall not bother dealing with those folk of straw which are our ordinary language uses of the word, more colloquial uses of the word, or even "the system". For the word has various technical usages, and it is, of course, to these that Dr. Stubbins appeals.

We can conceptualize the world as consisting of certain entities related to each other in specified ways. This is known as the systems approach. The approach becomes more interesting when possible to optionalize the connections between entities and describe what is in them. Sometimes this is outright simple; sometimes downright impossible.

Another use of systems theory refers to an arrangement as described above with the further stipulation that what goes on in the entities and/or their connections are simulated by computers. This form along with the growing capacity of computers promises much. The promissory notes are out, and what happens to them will affect the shape of social science. I suspect this is not the systems theory that Dr. Stubbins has in mind.

In practice, systems theory taught to human service professionals becomes pathetic. Rarely is an attempt made to operationalize a systems theoretical proposition and the student leaves with three misimpressions: First, to talk of something in terms of systems is to have said something about the system. (Translation: to talk about something in technical language is necessarily to have said something significant). Second, since all the world is a system, a particular system is not really different from any other. Third, a marvelous artifact of systems theory allows one to interpret its use not only as having said something, indeed something profound, but indeed as all there is to say. Thus, (I have taught systems theory and was instrumental in having it removed from one schools curriculum), systems theory becomes a way of isolating a problem, not looking for answers, and avoiding any need for empathy, telling the human service professional that he or she has some purchase on reality by learning an ostensibly professional language. This is not what Dr. Stubbins has in mind.

There is another use of systems that could have been meant by Dr. Stubbins. Obviously, there is more than one social system. People, society, economy, politics, etc., all interact. Best then to be aware of all levels of a system when trying to work with client to be rehabilitated may serve neither client nor oneself well. This version of systems is unexceptionable. It is also commonsensical. It is difficult to teach and best taught without the language of

systems but in the language of sociology, economics and politics.

If people could be concerned with systems, learning systems theory is the best way to ensure that they will not be. The facts that are decisive for disabled people are expressable without recourse to systems language, although they could certainly be expressed in that language if there was an advantage to it.

These facts include the following:

1. Like everyone else, disabled people are human beings.
2. Unlike everyone else, disabled people are an oppressed minority.
3. Disabled people should be encountered in the first instance on their terms, without preset categories, estimations, and roles.
4. The rehabilitation of disabled persons should be predicated on strengths, not weaknesses.
5. Theoretically, it is not disabled people who must adjust but society.
6. In significant measure, the rehabilitation worker and the disabled person are part of the same system.
7. In significant measure, the disabled person and rehabilitation counselor are different, this difference primarily arising out of the greater power of the rehabilitation worker.
8. It is easy to abuse power, easier still to rationalize power abused as being in the best interest of the client.
9. There are at least two people involved in the rehabilitation counseling situtation.
10. The rehabilitation worker is part of a society that at times does not have the best interest of the disabled at heart.
11. The rehabilitation counselor is part of a bureaucracy that holds neither the counselor's, nor the clients interest foremost.
12. At times, the rehabilitation counselor must see it as his or her role to act in a broader political arena following the lead of disabled people.
13. Rehabilitation and jobs are rights not gifts.
14. The rehabilitation worker must closely examine his or her actions to be sure they do not harm the disabled person.
15. It would be nice if the rehabilitation worker knew everything about everything. It would be nice for anyone. As elsewhere it is unnecessary here.

The rehabilitation counselor pays better heed to rehabilitation by recognizing the above facts than by being a part of an ideology. Systems theory, in particular, is impossible to teach and difficult to learn.

The propositions enumerated above are a subset of equally valid propositions that can be generated about the interactions of counselor and client and other levels of the system. The list is as long as research, common sense, decency, and judgment discovers.

Even in the small segment of the list already generated an inevitable component to rehabilitation is exposed that is important to, commonly over-

looked in, and easily submerged by a systems approach. In the first instance, the clinical situation itself is a political relationship. Politics involves *inter alia* power. In the clinical relationship, power ought to be used in the interest of the client but can be used otherwise. Further, the clinical situation occurs in bureaucratic, social, and economic environments, all penetrating it with power and the clinical situations in turn repenetrate them with power.

Further, policy is contingent on power for its continued effect, changes in policy require power, and changes in policy are involved in changing existing configurations of power. Thus, should one want to change the way things are, one had best have recourse to power. The perpetuation of the rehabilitation system as it exists and the realization of any changes involve power.

Rehabilitation counselors are frequently unaware of power. That is too bad. For a correct calibration of the vectors of power acting on counselor and clients is necessary for a correct calculation directed towards change in client and in other systems. If the counselor is unaware of power, he or she may rest assured that others will be aware of it. If the counselor has an interest in the client, a recognition of power and of politics in general is indispensable.

This political dimension, conspicuously lacking in the education of the rehabilitation counselor, must be confronted directly for rehabilitation furthering the dignity of the clients, the civil rights of an oppressed minority, and the equality, independence, and escape from the shackles of the clinic that disabled people seek.

Dr. Stubbins is correct. As currently constituted, rehabilitation is part of the problem not the solution. That need not be so. Dr. Stubbins' monograph is invaluable in pointing this out to us.

**William Roth, Ph.D**
**(Washington, D.C.**
**March 20, 1983)**

## A Professional Colleague Responds

The timeliness of Dr. Stubbins' monograph is evidenced by a letter to the editor in the April 1983 issue of the American Psychological Association's *Monitor:*

> **"That psychologists should complain that they are not being provided with funds to study unemployed people makes me very uneasy. Again, the needs of the 'research subject'—in this case, jobs—seem to be taking second place. It is tragic-comic to read of psychologists who believe that study of unemployed people will help identify those who are vulnerable to its effects, so that 'prevention or intervention' could be instituted: prevention or intervention of course meaning psychological treatment while doing not a whit to provide work for people studied.**
>
> **Psychologists, or so I have observed in some 15 years in this field, sometimes ensnare themselves in the rationales associated with 'adjustment' or 'coping,' with a consequent vision of themselves 'helping' others by helping them 'adjust' to unemployment, rather than joining in the work to correct the original problem. Sometimes my colleagues in psychology appear shamefully superficial to me. Some of them seem to feel, egocentrically, like a child—a deluded child—that the world is in our own heads."**
>
> Lance A. Olson, p. 6

Dr. Stubbins suggests that rehabilitation counselors in the United States labor under the same myth, and that university programs are "carriers" of the "clinical attitude."

There is enough truth in the accusation to cause educators to examine their attitudes and behaviors, but there is also misunderstanding that tempts an educator to cry "Foul." Universities function as "keepers of the meaning," continuing inquiry or transmitting knowledge that serves as a basis for reconstruction of theory and practice. To have continuity construed as being "carriers" relegates universities to the ranks of defective genes or contagious disease.

There is also an undercurrent in the monograph that polarizes disabled and nondisabled, a distancing accomplished through statements like "professionals are ill prepared to work with disabled citizens as activists" (p. 33). Curiously, Dr. Stubbins included in his earlier compendium, *Social and Psychological Aspects of Disability* an article by Tamara Dembo, written in 1969, which described the position of the insider and the outsider in rehabilitation sensitively and exhaustively. One wishes that Dr. Stubbins had adopted Dembo's analysis, including the respect for two viewpoints and joint investigation. The central points Dr. Stubbins raises are important; they should not be obscured by "us and them" tautology.

Fellow rehabilitation educators may also despair with the definition of counseling implied throughout the monograph. Much effort has been spent trying to differentiate rehabilitation counseling from psychotherapy, yet Dr. Stubbins seems to utilize traditional psychotherapy as his reference for the "clinical attitude." The Commission on Rehabilitation Education standards,

and Certification requirements for Rehabilitation Counselors testify to the goal-orientation of the rehabilitation counselor and the knowledge and skill base which is attuned to environmental factors. Dr. Stubbins seeming unfamiliarity with these standards and with what is currently being taught in counseling coursework is a gap in the monograph through which misunderstanding can flow.

Scrutiny of syllabi in pre-practicum coursework would reveal use of resources such as Ivey and Simek-Downing's text which emphasizes the choice of working on environmental change or individual adjustment. Beginning counselors are being taught to conceptualize persons in the largest contexts. Dr. Stubbins' list of references and discussion of the clinical attitude is devoid of recognition of newer strategies that are described as "ecological" in nature. The "nesting" of individuals within micro, exo, and macro systems has been the subject of much recent research and teaching (Belsky, 1980; Bronfenbrenner, 1979; Garbarino, 1977). Analyzing and solving problems at different levels has always been the chief distinction of rehabilitation counselors from other "therapists"; it is distracting, at the least, for Dr. Stubbins to present the rehabilitation counselor as a traditional psychologist and to be seemingly uninformed about new research and training efforts at ecological intervention.

The final source of misunderstanding in the monograph is the inconsistent position expressed toward specialists and generalists. In the comparison of the British DRO, the rehabilitation counselor in the United States is criticized for lack of placement expertise. Does Dr. Stubbins suggest the proliferation of the "placement specialist"? Given his views on the importance of a broad education, probably not, but Dr. Stubbins' position is unclear in the monograph.

If educators can suspend judgment, setting aside the "bum rap" given universities, rehabilitation educators, and rehabilitation counselors in parts of the monograph, some fresh thinking and exchange can occur. Certainly, we are what we have been educated to be. Rehabilitation educators do not find economics, history, sociology, and political science familiar territory. Larger contexts do promulgate feelings of learned helplessness. What could be done to increase rehabilitation educators' understanding of systemic problems? There is a fragmentary literature already begun in rehabilitation policy analysis and economic trends (Purtilo, 1981; Berkowitz, 1979; Hammerman and Maikowski, 1981; Perlman, 1980). There are readable economists and sociologists whose ideas are directly applicable to research and training (Reich, 1983, Starr, 1983; Magaziner and Reich, 1982). Students can be taught the "facts" of world and national economy, although an appropriate response to the following quotation is uncharted:

> **"Certain trends are evident: the increasing consumption of social services, the decreasing work-force base for support of such services, the changing population structure in the world's different regions, the**

**diminution of the world's available natural resource supplies which foretells radical alterations in consumption and development patterns."** *(p. 206. Hammerman, Rehabilitation International, 1981)*

Continuing education for rehabilitation educators could be profitably spent in the study of these disciplines once removed from our academic preparation.

Being open to change and acknowledging the limitations of our current instructional repertoire is a professional obligation for rehabilitation educators. Dr. Stubbins has surely gotten our attention through this monograph. Whether intended or not, the results of the study indicate a need for the most broadly prepared professional to deal with internal and external factors in rehabilitation. Dr. Stubbins noticed these characteristics of DROs:

—DROs gave first attention to easy placements and see clients as incapable of change

—DRO-client relationships were marked by diffidence on the part of the client and paternalism on the part of the DRO

—DROs did not question stereotyped notions of occupations recommended by physicians

Stubbins suggests that value attitudes underlying the antithesis of these behaviors are the product of lengthy exposure to a "social science education." Is this not supportive of the notion of professional education? An earlier study by Carnes (1979) in which he compared five nations and their rehabilitation practices also pointed to the need for professional personnel:

> **"Instead of lower educational levels, the writer concludes that present or even higher professional education for rehabilitation counselors would result in workers better able to differentiate between those clients who require extensive benefits to cope with life and those for whom such provisions would discourage motivation. Increased costs of education and salaries would more than be returned by savings in costs of pensions, workshop support, and innumerable hidden expenses to society." (p. 222).**

Dr. Stubbins, perhaps unintentionally, also appears to be calling for more education in his monograph. Just reward for the rehabilitation educator who

*Richard Desmond, Martha Walker and Susan Daniels*

wades through the affect-laden content.

Rehabilitation education has a challenge in developing course content and process that will produce professionals effective in a changing economy. Robert Reich at least provides a direction, how such a professional would look "on hoof": "Skills relevant in the newly competitive world economy are how to collaborate with others, to work in teams, to speak foreign languages, and to solve concrete problems" (p. 55). Now rehabilitation educators must provide the means to this end.

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**Martha Walker**
**The National Council**
**on Rehabilitation Education**

## Comments on The Clinical Attitude in Rehabilitation

The monograph is a major contribution to the field of rehabilitation. It is thoughtful and stimulating and could be profitably read by everyone concerned with rehabilitation.

Dr. Stubbins made a basic distinction between the *clinical approach* which emphasizes the individual and his characteristics, history, training, and the assessment and improvement of his skills. A *social-environmental approach*, on the other hand, emphasizes such variables as the attitudes of other persons and the policies of various governmental agencies. I agree with Dr. Stubbins that there has not been nearly enough emphasis on the social-environmental approach in rehabilitation. Although the clinical approach is needed, and can be useful, it should be supplemented by the other. Not all of the problems of disabled persons lie within the person. Nor can all of them, perhaps not even most of them, be attributed directly to the person's disability. Instead, many of the problems and difficulties faced by disabled persons can be attributed to factors in the physical/social environment. In the physical environment, architectural barriers often inhibit accessibility and mobility. In the social environment, people's attitudes often create problems and difficulties in areas such as education, employment and social interaction. These latter types of difficulties are often much more important and more pervasive than difficulties attributable to the specific disability.

Another point made in the monograph is that rehabilitation researchers and practitioners have a stake in preserving their own status, which often results in support of the *status quo* and resistance to change. "Not making waves" is often perceived as appropriate behavior which, it is assumed, will lead not only to personal advancement within an organization, but also to having articles accepted for publication, and to obtaining grants. While there may be some truth to this, it is not the whole truth. People in the field must recognize that in the long run the future of rehabilitation, and consequently the future of everyone who works in the field, depends on our being able to *critically* examine our assumptions and our procedures and to institute changes that will make our techniques and procedures more effective. We should not fear change. It points the way to the future.

I was disturbed by a statement on page 9 of the monograph: "Prejudice against the disabled is regarded as a given." I was distrubed by the statement not because it is untrue, but because it *is* true. It is all too true, and yet is often ignored. But it should not be ignored. We must not accept prejudice toward disabled persons as a "fact of life." We should be doing all that we can to deal with such prejudice. Changing prejudiced attitudes is a task to be undertaken not only by those persons actively engaged in studying and changing attitudes, but by everyone concerned with rehabilitation and the welfare of disabled persons as well as by all disabled persons themselves.

The importance of the social environmental approach in contrast to the clinical approach is also indicated by two contrasting statements made in the monograph. One statement concerned the very important, and usually ignored, fact that employment of disabled persons in the United States reached its highest level ever during World War II. In contrast, consider the statement that "increasing injections of professional experts have not significantly improved the job placement batting average." The implications are clear.

In the monograph, Dr. Stubbins pointed out the major error of locating the disability in the client. Here, I only partly agree with him. As indicated earlier, I agree with him that we must change our approach and emphasize the importance of factors in the environment. On the other hand, we must not make the mistake of believing that these are the only important factors. While we should not overemphasize the importance of factors residing within the individual, we should not ignore them. Sometimes they are very important. The behavior of persons who are disabled is influenced not only by environmental factors, but also by their attitudes toward their disability and their attitudes toward disabled persons. These attitudes, which may be considered to reside within the person as a result of past learnings are sometimes major influences on behavior, more important than either the disability itself or environmental factors.

At one point in the monograph Dr. Stubbins asked the question "must disabled persons be competitive?" Many people would say that it is not necessary, and some would claim that it is harmful. I am inclined to disagree. It seems to me that as long as disabled people live in a competitive society, and most people characterize the United States as competitive, it is preferable for them to compete as much as possible. I am not arguing for competition *per se*. I am arguing for attempting to conform to important societal norms. Obviously, not everyone can compete in all areas; nor is it necessary. But to the extent that one is able to compete, one should. Although there will probably always be a need for sheltered workshops, competitive employment should be much preferred.

Dr. Stubbins also made the very important point that although the topic of "acceptance of disability" is often discussed, and usually extolled, it is seldom defined. This point is very well taken. We need, first, to precisely define this phrase. What does it include, and what are the behavioral implications? Then after having defined the term, we must discuss the conditions under which attitudes of acceptance are desirable and the conditions under which they are undesirable. Does acceptance of disability imply that the person perceives himself/herself as a member of the class of people referred to as disabled? Does it imply that he/she will do nothing to improve his/her physical condition? Does it imply that the person is happy with the disability? Or does it simply imply that the person accepts it as a "fact of life" similar to height or eye color, each of which can be somewhat changed through the use of "prosthetic devices?"

Finally, the question is raised "How can society be changed?" Obviously, there is no single answer. Getting laws passed is one way. Studies have indicated that laws can be efficacious in changing attitudes. We are all familiar with the effects of various laws both in the United States and in other countries. Changing people's attitudes is another way. By changing attitudes of people, particularly the attitudes of legislators and other opinion leaders, we can bring about changes in society. Finally, we must initiate programs designed to change the attitudes of members of the helping and teaching professions, persons such as doctors, rehabilitation professionals, psychiatrists, psychologists, social workers, teachers and school principals. All of these groups have been shown to have mostly negative attitudes toward persons with disabilities. They must be educated! All of us must participate in this educational process. And Dr. Stubbins and his monograph can be very helpful in this enterprise.

**Harold Yuker, PhD.**
**(Hofstra University**
**March 18, 1983)**

## The Role of Academic and Scientific Communities

For me, the most intriguing part of our discussion was the role of the social sciences as transmitters of cultural values that affect the well-being of disabled persons.

It is interesting to note that of the four main social sciences (psychology, sociology, political science, and economics), rehabilitation professionals have gravitated toward psychology—the one social science that emphasizes intervention at the most individual level. Psychology, as a field of inquiry and practice, is often appealed to as a way of legitimizing rehabilitation practice. More importantly, however, psychological interpretations divert attention from larger social, political and economic problems. Thus, psychology is much less threatening to established social structures since it is the individual and not society that must change. By focusing on individual shortcomings, psychology and rehabilitation affirm the values and institutions of society-at-large. In return, society confers its approval upon professional rehabilitation.

The fields of rehabilitation and disability policy need the infusion of other social science disciplines that can help focus attention on larger macrosocietal issues. Consider economics: Employment of disabled persons is as much a function of the larger economy as it is a function of individual preparedness. As discussed in our meeting, World War II represents a very interesting chapter in the employment of persons with disabilities. During the war, shortages required the employment of every available disabled person. And according to anecdotal evidence, the work records of disabled persons in the war were excellent. Yet, after World War II, disabled persons were again in the backwaters of our economy.

Although other social science disciplines can help direct us to larger issues, we must be cautious. Even a discipline such as economics is loaded with assumptions that can deflect attention from larger economic forces that impinge on the lives of persons with disabilities. At the core of contemporary economic analysis is consumer demand theory in which the concept of *individual* utility maximization is the theoretical point of departure. Again, it is the *individual* who is the basic unit of analysis. Societal or community well-being is merely the sum of individual utilities as mediated through the competitive market system. According to economic theory, the objective of public policy is to redraw the "budget constraint" that determines the point at which the individual will maximize his utility.

By focusing on the individual as the locus of the problem we also reinforce society's notion of disabled persons as devalued and stigmatized people. I am convinced that if persons with disabilities are to realize their full rights as disabled citizens we must draw attention to the larger social and environmental origins of the handicapping condition.

A central issue implicit in the Stubbins monograph is how the nonclinical/environmental approach can gain professional attention and acceptance and thereby also redefine the problem of disability in a way that will secure for disabled persons a less stigmatized role in society. In this regard, I believe that the academic and scientific communities have a tremendous role to play. By taking the matter of disability seriously, these communities can cast their mantle of legitimacy on a subject previously stigmatized. However academia and science must go further: they must avoid problem-defining theories that focus exclusively on the individual and consider theoretical and empirical models that take into account various environmental interactions.

**Gerben DeJong, Ph.D.**
**(Clark University**
**March 24, 1983)**

## Some Conclusions Reached at Meeting at Clark University

**Joseph Stubbins**

The participants felt no need to review or respond to the criticisms of the clinical model mentioned in Stubbins' monograph and a consensus was quickly reached to proceed with alternatives to individual methods of rehabilitation.

The major agreement was that policy studies in rehabilitation were a piecemeal affair, that academics, administrators and practitioners showed little interest in policy matters (except as their immediate professional interests were touched). A number of reasons for their disinterest were mentioned e.g., the lack of interdisciplinary communication essential to policy studies, the department organization of universities, competition for academic turf and the absence of rewards for those pursuing interdisciplinary approaches.

No one present thought that stimulating interest in policy studies would be easy in the light of the additional obstacles that stand against the rational examination of how funds should be allocated to various approaches to improving the social and economic status of disabled persons. Perhaps, most obvious of these obstacles is that some disability categories are well organized politically and derive obvious advantages from the current disarray and lack of co-operation among the remaining categories. *DeJong's* suggestion of the need for a Center for Policy Studies was well received though the idea was not discussed in detail.

The two major exemplars of systems approaches were the mental retardation movement and independent living movement. The remarkable advances of the last 30 years were largely changes in public atttitudes that helped to normalize the lives of mentally retarded persons. Clinical methods had a minor part in these advances. The Independent Living movement was credited with changing the consciousness of disabled persons so that they were able to articulate their unmet needs independently of the professional interests of the various practitioners which served them.

Was the present a strategic time to raise questions about the re-allocation of public funds from clinical to environmental approaches? This question hovered in the background as well as the feeling of general discouragement engendered by the economic recession. In any event, the transition to ecological approaches would take a decade or more and it was difficult to anticipate factors which might facilitate and impede this transition. For the present, we are in an early phase of change as evidenced by the fact that there is no widespread recognition that clinical methods might be less cost effective than ecological ones, that considerable resistance would be raised against rehabilitation methods not directly measured by job placements in the labor market, and there is probably little public support for spending

money to enhance the quality of life of disabled persons as in enlarging their self-sufficiency.

There was agreement that these latter issues were related to existing social welfare policies covering the various categories of income maintenance and services for disadvantaged segments of the population. But the special status enjoyed by vocational rehabilitation programs as compared to other social welfare programs has decreased. Only in recent years have questions been raised about their value by two different constituencies: the political ultra-right and the disabled associated with the independent living movement. This situation makes the transition to systems approaches complicated.

*Joseph Stubbins*

*Paul Cornes and William Roth*

## Assessment of WRF Meetings on the Clinical Attitude in Rehabilitation and Alternatives—March, 1983

**Paul Cornes**

This programme was arranged to disseminate and promote utilization of the WRF monograph on *The Clinical Attitude in Rehabilitation* by Joseph Stubbins. Meetings included formal presentations to audiences of rehabilitation counselors and rehabilitation counseling educators. They also included opportunities for informal exchanges on some of the main issues raised by the monograph with officials responsible for administering vocational rehabilitation programmes at Federal and state levels; with rehabilitation practitioners employed in the public, private and voluntary sectors; and with representatives of such other relevant professions as rehabilitation medicine, psychology, social work, economics and politics. Regrettably, the short nature of the visit meant that the only people with disabilities seen were those who also represented one or other of these mainly professional interest groups.

The programme had a well varied format and was extremely well organised. Although, in one or two instances, a better balance between time allocated to presentations and discussion might have been desirable, there can be little doubt that the *dissemination* objective was most successfully achieved. *Utilization*, however, is a different and inevitably longer-term objective. Its eventual achievement will depend on many factors, including what is done to promote continuing discussion of the administrative, professional and practical implications of Stubbins' thesis; to reinforce the initially positive response to these ideas exhibited by many rehabilitation educators and to influence the receptivity of practitioners to new approaches based upon them. The evidently quite substantial investment in continuing education for practitioners was most impressive. Such arrangements will clearly have a crucial role to play in insuring the success of further utilization efforts. In the meantime, plans to prepare a *Rehab-Brief* and to bring together the various reactions to the Stubbins original monograph in a special edition of *Rehabilitation Monograph*, if implemented, will hopefully encourage wider interest. In the longer-term, though they will need to be reinforced by other promotional and educational initiatives.

How much further effort of this kind might be needed is difficult to judge. On the one hand, while the WRF meetings indicated a measure of agreement with, and acceptance of, Stubbins' thesis on the part of the majority of participants, there were signs that some educators and practitioners have yet to be convinced. It is suspected that the latter reaction may be the more representative of grassroots opinion amongst rehabilitation counselors. On the other hand, Stubbins is not alone in questioning the underpinning ideology and modus operandi of rehabilitation counseling practice. Rehabilitation profes-

sionals have been invited to confront similar issues by DeJong's elaboration of the independent living paradigm and Anderson's analysis of the appropriateness of a clinical model to many aspects of rehabilitation medicine decision making. That the same questions are being asked in other, non-vocational areas of rehabilitation may therefore herald a changing climate of increasing receptivity to alternative conceptions of the aims and requirements of rehabilitative practices.

The acid test will be the incorporation of such alternatives in professional education and training programmes and, ultimately, in everyday practice and procedures. For the present, while educators showed considerable interest in such ideas, there is little evidence of any practical implementation. The necessary revisions to training courses for new entrants have yet to be made, and continuing education is still mainly directed to marketing the desirability of new developments based on these alternative perspectives rather than the dissemination of good practice based on existing examples. Although this may simply reflect the comparative recency of these new ideas, my brief visit suggested that any further progress will almost certainly depend on other factors. The most important of these will be the degree of encouragement and support that officials at both Federal and state levels give to educators and practitioners not only to explore these ideas but also to implement and evaluate new developments in policy and service delivery deriving from them. Achieving these goals will undoubtedly require that attention is paid to removing or reducing some of the attitudinal and organisational obstacles that Stubbins has identified as possibly impeding development of more effective vocational rehabilitation programmes.

Rehabilitation counseling practice has generally concentrated, or has been obliged to concentrate, on quite a limited range of client-centred interventions. Its primary focus has therefore been on rehabilitative processes rather than on effective resettlement outcomes. Over the years, the profession has achieved high levels of skill and expertise in such methods, and has been to the fore both in developing diagnostic and assessment procedures and in devising clinical and behavioural rehabilitative techniques. Recent contact with rehabilitation counseling educators and practitioners has reinforced my longstanding admiration of these accomplishments. At the same time, however, it has also made me much more aware than before of the extent to which rehabilitation counseling has tended to develop in comparative isolation from related professions and other relevant social science disciplines.

This was highlighted in meetings at Hofstra and Clark Universities and in discussion with the director of the National Institute of Handicapped Research, all of which underlined the extent to which professional practice has been informed by an essentially clinical psychology of disability at the expense of a more embracing social psychology of handicap. While not overlooking the significance of clinical appreciation of clients' problems or the relevance of

clinical methods in particular instances, the latter approach would require that attention is also paid to such wider issues as attitudes towards people with disabilities or how payment of disability pensions or allowances may influence recipients' attitudes regarding return to work.

At present, there is an imbalance between these perspectives, both in support for their respective development and in the range of practical applications deriving from each. An examination of existing professional training arrangements may suggest why this has occurred. Counselor education appears mainly to have been developed in faculties of education. It may therefore have drawn less on conceptual and theoretical developments in general psychology or in other relevant social science disciplines than might have been the case under other circumstances. New developments, like those which exemplify a systems perspective, will require a much more multi-disciplinary approach. In the longer-term, therefore, such breadth of outlook will need to be more adequately reflected in training course syllabuses and in the research and teaching interest of staff.

While it would be inaccurate to suggest that rehabilitation counseling has been entirely unresponsive to the need to develop future policy and practice in ways which reflect a more multi-disciplinary perspective, concern to preserve its long-established professional identity and methods could easily result in some counselors losing touch with changes in clients' attitudes and expectations or in vocational rehabilitation services failing to keep abreast of changing labour market conditions. Certainly there was some evidence during my visit that where experimentation with alternative approaches has been tried it has mainly been initiated in the voluntary and private sectors of rehabilitation practice or by such other professions as social workers or rehabilitation nurses or, as in the case of the Projects with Industry programme, through newly forged patterns of partnership between these sectors and the Federal-state system.

Public sector vocational rehabilitation services may therefore risk being overtaken by developments in other spheres, and may already have lost their traditional leadership role in the development and implementation of new practices and procedures. Reasons for this turn of events can only be surmised. One possibility is that public sector services are required to serve a different clientele from that dealt with by voluntary/private sector services or by other professions. Another possible reason is that voluntary/private sector services are more readily able to experiment with alternative approaches because they are much less constrained by formal mandates or by official, political and professional expectations about the kind of services required. It is certainly a common enough experience that the same legislation which enables the introduction of a public service at one point in time may actually impede its further development or accommodation to changing circumstances later on. There have been many changes in the pattern of disablement, in the attitudes and expectations of disabled people, in the composition of the labour

market and in the nature of work since the foundations of public sector vocational rehabilitation services in the United States were first laid. It may therefore be timely to re-examine some of the basic assumptions which have guided development of policy and services to date, including an assessment of their continuing relevance to vocational rehabilitation in the 1980s and beyond.

From these observations, it will be apparent that impressions gained from my brief WRF visit have mainly served to "validate" Stubbins' thesis regarding the limitations of a mainly clinical model for vocational rehabilitation decision making and the need to develop future policy and practice on a broader, multi-disciplinary basis, embracing both individual (clinical) and societal (systems) strategies of labour market intervention. But, as I am sure Stubbins would be the first to concede, the case for new developments has been argued only in the most generalised terms, leaving details (about, for example, the shape which American systems approaches might assume or the most effective mix of clinical and systems approaches) to be worked out in future debate and, hopefully, in the light of trials with alternative practices and procedures.

This scenario for the further development of policy and services is dependent on the funding of policy studies to analyse current policies and to evaluate their effectiveness and also, where necessary, to propose alternative service delivery models. It is also dependent on the subsequent availability of similar resources for field trials with such alternatives. Given existing constraints on rehabilitation counselor education programmes, Federal funding, either in the form of additional outlay or from a re-allocation of existing funds, will probably be crucial to achievement of these developments. Support for policy studies would be a natural extension to the assistance that is already given to research and training centres; to support programmes to help people with disabilities lead more independent lives; and to develop new patterns of liaison between Federal-state vocational rehabilitation services and those in the voluntary and private sectors.

An examination of previous research on vocational rehabilitation would demonstrate that attention has mainly been focused on the refinement of clinical practices based on client-centred interventions. In the few instances where overarching policy issues have been studied, research has tended to be guided by macroeconomic theories which do not differentiate between different sub-groups of labour market participants. Problems that disabled people experience in entering the labour market or in obtaining a reasonable share of employment opportunities have therefore generally been examined from fairly extreme perspectives. A main aim for new policy studies would be to address these problems more directly. The following subjects might be considered suitable for further investigation in a new programme of policy studies:

- **Identification of the main assumptions guiding development of policy to date and an assessment of their continuing relevance;**
- **Identification of the main aims of contemporary policy and practice and an evaluation of the extent to which (a) they remain relevant and (b) they are realised in practice;**
- **Studies of how the labour market actually operates for disabled people paying particular attention to any differences in personal characteristics or in labour market experiences of such sub-groups as (a) those who enter/return to work without any specialised assistance (b) those who enter/return to work following contact with specialised services (c) those who fail to enter/return to work following contact with specialised services;**
- **Studies of disabled people in employment to discover the kinds of problems they encounter and how such problems are solved. Such people are a very neglected group from whose experiences there may be much to learn;**
- **An examination of vocational rehabilitation without the Federal-state system. Studies of this kind would enable comparisons to be made between the clientele of different services and those dealt with by the Federal-state system and between the aims, organization, operation and effectiveness of such services. Attention might also be directed to ascertaining some of the reasons for the development of services in the voluntary and private sectors and for the increasing involvement of such other professions as social work and rehabilitation nursing. A main aim of this line of enquiry would be the identification of methods, projects or innovative programmes which can be utilized on a wider scale within the Federal-state system;**

**Studies of employers' occupational health and personnel policies as they impact on disabled job applicants and employees;**

- **Design, implementation evaluation of action research or demonstration projects, drawing on the results of all other lines of enquiry, as model projects or programmes to improve the effectiveness of vocational rehabilitation services.**

Rehabilitation counselors are familiar with most if not all of these problems. In some instances, they are taking or may have already taken steps to deal with them. It might therefore be expected that they will lay claim to any funding that is made available for policy studies. Such interest and involvement should of course be encouraged, although not at the expense of other relevant disciplines. It is equally important to ensure that representatives from such other areas as social psychology, social policy and administration, sociology, politics and economics have opportunities to contribute to the conduct of policy studies, and that disabled people themselves, or organisations representing their interest, are consulted over and otherwise involved in the development and implementation of research and development projects. In the short-term, practical, conceptual and methodological insights from these other interest groups will inevitably mainly be of benefit to research. However, it should not be overlooked that, in the longer-term, their contributions should be reflected both in professional training programmes and, later, in policy decision making and everyday practice. Development along these lines should therefore help rehabilitation counseling to acquire a more multi-professional orientation and, hence, to become more effectively equipped to deal with clients' requirements for vocational rehabilitation services in the late 1980s and beyond.

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**New York, NY 10016**

Howard A. Rusk, M.D.,
**Chairman of the Board**

Howard A. Rusk, Jr.
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James F. Garrett, Ph.D.,
*Executive Vice President, and Principal Investigator*
Diane E. Woods,
*Project Director*

Theresa Brown,
*Project Secretary*
Sylvia Wackstein,
*Secretary-Treasurer, WRF*

**COOPERATING INTERNATIONAL ORGANIZATIONS**
(U.S. Based)

**University Centers for International Rehabilitation**
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Director, Michigan State University,

**Rehabilitation International U.S.A.**
Philip Puleio, Ph.D., Director
New York

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**PEER REVIEW UTILIZATION PANEL (ADVISORY COMMITTEE)**
**APRIL 1983-September 1983**

**FORMER WRF FELLOWS**

Dr. Sheila H. Akabas, Director
*Industrial Social Welfare Center*
School of Social Work
622 West 113 Street
New York, NY 10025

Donn Brolin, Ph.D., Professor
*University of Missouri-Columbia*
16 Hill Hall
Columbia, MO 65211

Thomas P. Anderson, M.D.
*Department of Physical Medicine and Rehabilitation*
Medical School
University of Minnesota
Twin Cities
860 Mayo Memorial Bldg., Box 279
420 Delaware Street, SE
Minneapolis, MN 55455

Dr. Richard E. Desmond, Chairman
*Department of Special Education & Rehabilitation*
University of Pittsburgh
School of Education
4616 Henry Street
Pittsburg, PA 15260

Ruth R. Green, Administrator
*N.Y. League for the Hard of Hearing*
71 West 23 Street
New York, NY 10010

Dr. Kenneth Mitchell, Director
*The Industrial Commission of Ohio Rehabilitation Division*
106 North High Street
Columbus, OH 43215

Gini Laurie
*Rehabilitation Gazette*
4502 Maryland Avenue
St. Louis, MO 63108

**Others**

Dr. Mark Fuhrer
*Texas Institute for Rehabilitation and Research*
1333 Moursund Avenue
Houston, TX 77030

Claude A. Myer, Director
*Division of Rehabilitation Services*
620 North West Street, Box 26053
Raleigh, NC 27602

Carolyn Vash, Ph.D.
*Institute for Information Studies*
35 East Las Flores Drive
Altadena, CA 91001

**SPECIAL CONSULTANTS TO PROJECT:**

Leonard Diller, Ph.D.
*Chief, Behavioral Science*
Institute of Rehabilitation Medicine
NYU Medical Center
400 East 34 Street
New York, NY 10016

Dr. John Muthard, Chairman
*Dept. of Rehabilitation Counseling*
University of Florida
Box J-175, J. Hillis Miller Health Ctr.
Gainsville, FL 32610